



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 27, 2026

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

RE: License #: AS230010636  
Investigation #: 2026A0581022  
Nova Vida Inc

Dear Harry 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) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

Cathy Cushman, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(269) 615-5190

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS230010636
<b>Investigation #:</b>	2026A0581022
<b>Complaint Receipt Date:</b>	03/05/2026
<b>Investigation Initiation Date:</b>	03/05/2026
<b>Report Due Date:</b>	05/04/2026
<b>Licensee Name:</b>	Nova Vida Inc
<b>Licensee Address:</b>	Box 92 1693 N Otto Road Charlotte, MI 48813
<b>Licensee Telephone #:</b>	(517) 204-6216
<b>Administrator:</b>	Harry Gross
<b>Licensee Designee:</b>	Harry Gross
<b>Name of Facility:</b>	Nova Vida Inc
<b>Facility Address:</b>	4535 Bittersweet Lane Lansing, MI 48917
<b>Facility Telephone #:</b>	(517) 204-6216
<b>Original Issuance Date:</b>	02/07/1987
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/07/2024
<b>Expiration Date:</b>	07/06/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED



## II. ALLEGATION

	<b>Violation Established?</b>
On or around 03/01/2026, direct care staff, Adonis Sokamte Sr., struck Resident A.	No
Additional Findings	Yes

## III. METHODOLOGY

03/05/2026	Special Investigation Intake - 2026A0581022
03/05/2026	APS Referral - Made online
03/05/2026	Special Investigation Initiated – Letter - Made referral to APS
03/05/2026	Contact - Document Received - Licensee designee, Harry Gross, forwarded Incident Report evening of 03/04/2026, which was reviewed on 03/05/2026
03/05/2026	Contact - Document Received - Reviewed email from Harry Gross received on 03/04/2026
03/06/2026	Contact – Document Sent – Email to Harry Gross.
03/08/2026	Contact – Document Received – Email from Harry Gross.
03/09/2026	Contact - Face to Face - Interview with direct care staff, Heather Jamieson
03/10/2026	Contact - Telephone call made - Interview with licensee designee, Harry Gross
03/10/2026	Contact - Telephone call made - Interview with direct care staff, Danette Young.
03/10/2026	Contact - Face to Face - Interview with direct care staff, Kristina Faust
03/10/2026	Contact - Face to Face - Interview with Adonis Sokamte Sr.
03/19/2026	Inspection Completed On-site -Observed Resident A and conducted inspection.

03/19/2026	Contact - Telephone call received - Interview with Licensee Designee, Harry Gross.
03/19/2026	Exit Conference with licensee designee, Harry Gross.
03/20/2026	Contact - Document Sent - Email to Harry Gross.
03/22/2026	Contact - Document Received - Email from Harry Gross.
03/25/2026	Contact - Document Sent - Submitted variance request to Director.

**ALLEGATION: On or around 03/01/2026, direct care staff, Adonis Sokamte Sr., struck Resident A.**

**INVESTIGATION:** On 03/05/2026, I reviewed an Incident Report (IR), dated 03/01/2026, provided by the licensee designee, Harry Gross. The IR documented on 03/01/2026 at approximately 7:30 pm, a direct care staff reported to Harry Gross that another staff observed a staff striking Resident A in the head during a scuffle over an item Resident A had in his hand. The IR did not identify the staff involved.

On 03/08/2026, Harry Gross identified each of the staff involved in the alleged incident on 03/01/2026.

On 03/09/2026, I interviewed direct care staff, Heather Jamieson. Heather Jamieson stated she was not working at the time of the alleged incident; however, she stated the incident was relayed to her by direct care staff, Kristina Faust, on the morning of 03/02/2026. Heather Jamieson stated she notified the licensee designee, Harry Gross, upon receiving this information.

Heather Jamieson stated it was reported to her that on 03/01/2026 at approximately 7:30 pm, Kristina Faust attempted to retrieve a Miralax bottle cap from Resident A, as he was not permitted to have it, but Resident A refused to relinquish the item. Heather Jamieson stated that Kristina Faust reported that staff, Adonis Sokamte Sr., approached Resident A from behind, at which time the interaction became face to face, and Adonis Sokamte Sr. struck Resident A in the head with an open hand. Heather Jamieson stated Kristina Faust did not report whether Adonis Sokamte Sr. made any verbal statements during or after the incident and did not report observing any visible injuries to Resident A. She stated Kristina Faust further reported that although Adonis Sokamte Sr. was unable to obtain the item, she was later able to retrieve the cap and administer Resident A's medication without further incident.

Heather Jamieson stated there are no cameras in the facility that would have captured the incident, including the medication room where the incident reportedly occurred. She stated that only Kristina Faust and Adonis Sokamte Sr. were present

at the time of the incident. Heather Jamieson further stated Resident A is nonverbal. Additionally, she stated upon her arrival to work at approximately 9 pm on 03/02/2026, she did not observe any visible injuries to Resident A's face or head.

Heather Jamieson identified staff, Danette Young, as working the overnight shift from 03/01/2026 through 03/02/2026. She stated she has not worked directly with Adonis Sokamte Sr., as he primarily works day shift while she works the overnight shift.

On 03/09/2026, Harry Gross documented in an email that English is Adonis Sokamte Sr's second language with French being his primary language. Harry Gross further documented Adonis Sokamte Sr. requested his son Adonis Sokamte Jr., who is also employed at the facility, to assist with interpretation during the interview.

On 03/10/2026, I interviewed Adonis Sokamte Sr. with the assistance of his son Adonis Sokamte Jr. Adonis Sokamte Jr. assisted in clarifying questions as needed, although Adonis Sokamte Sr. appeared to understand the questions being asked.

Adonis Sokamte Sr. stated has been employed for the licensee for approximately 1.5 years and typically works morning and afternoon shifts. He stated he worked on 03/01/2026 from 9 am to 9 pm alongside Kristina Faust.

Adonis Sokamte Sr. stated prior to the incident occurring, he was in the laundry room while Kristina Faust was in the staff's office and medication room. He stated the rooms were near one another. He stated at approximately 6 pm, he heard Kristina Faust call for Resident A. He stated Resident A sounded excited and sounded like he was moving around. Adonis Sokamte Sr. stated he went to the office area to see what was going on and observed Kristina Faust holding Resident A's hands and trying to remove, what he later determined to be, container caps.

Adonis Sokamte Sr. stated Resident A has a history of taking tops from containers and placing them in the toilet. Adonis Sokamte Sr. stated he asked Resident A to return the tops and directed him to give them to Kristina Faust, which Resident A did. He stated he observed the caps in Kristina Faust's possession.

Adonis Sokamte Sr. stated he then guided Resident A away from the doorway. He stated Resident A left the doorway voluntarily without physical contact from him. He stated his interaction with Resident A only lasted only a few minutes.

Adonis Sokamte Sr. denied striking, hitting, or otherwise making physical contact with Resident A.

On 03/10/2026, I interviewed direct care staff, Kristina Faust, who stated she has been employed at the facility since December 2024 and works full time on various shifts as needed. She stated she was working from 9 am to 9 pm on the day of the

incident, which she estimated occurred between 7 pm and 8 pm, approximately 7:30 pm.

Kristina Faust stated she was administering medications to another resident when she observed Resident A enter the medication room and remove the cap from an empty Miralax container. She stated the medication cabinets were locked; however, the room itself was not locked. She stated she attempted to retrieve the cap from Resident A, but was unsuccessful due to his strength and she indicated she intended to retrieve the cap later as she did not find Resident A holding the cap to be dangerous or worth escalating any behaviors to retrieve it.

Kristina Faust stated that as Resident A exited the medication room staff, Adonis Sokamte Sr. approached from the nearby laundry room area. She stated that Adonis Sokamte Sr. grabbed Resident A's right arm in an attempt to retrieve the cap. She stated that Adonis Sokamte Sr. then made contact with Resident A's head using his left hand, which she described as a "tap" or "jolt" to the top/back right side of Resident A's head, indicating it appeared intended to correct Resident A's behavior.

She stated Resident A did not react verbally or physically following the contact. She stated she did not observe any bruising, redness, or swelling to Resident A's head.

Kristina Faust stated Resident A retained the possession of the cap and then ran to a chair in the living room and sat down. She stated she later retrieved the cap from Resident A and redirected him by providing him with one of his favorite toys, after which Resident A ceased having any type of behaviors.

She stated she had not previously worked with Adonis Sokamte Sr. and had not observed similar behavior in the past. She stated that following the incident, Adonis Sokamte Sr. did not make any statements regarding the interaction and resumed his duties. Kristina Faust stated she was in shock and did not immediately respond to the incident, but was able to continue administering medications and assist residents with bedtime routines.

She stated all residents went to bed at approximately 8 pm and that the next shift staff arrived around 8:30 pm. She stated she ended her shift between 8:30 pm and 9 pm and has not worked with Adonis Sokamte Sr. since the incident.

On 03/10/2026, I interviewed direct care staff, Danette Young, who stated she has been employed with the licensee since 2014 and works full time on the overnight shift, which is 9 pm until 9 am. Danette Young confirmed she worked the overnight shift beginning 03/01 and arrived at the facility at approximately 8:30 pm to 9 pm. She stated that upon arrival, she was informed that Resident A had removed pump lids or caps from various containers in the bathroom. She identified that Kristina Faust and Adonis Sokamte Sr. were working at the time of the incident.

Danette Young stated that upon arrival, Kristina Faust was in the medication room and informed her there had been an incident involving Resident A removing lids. She stated the lids have been removed from items such as lotion, shampoo, and hand soap. She stated Kristina Faust did not report that Resident A removed any items from the medication room, including a Miralax container cap. Danette Young stated she then went to the bathroom area, where she observed staff had replaced pump lids with flat lids and that the removed lids had been discarded. She stated that Kristina Faust indicated staff had already retrieved the lids from Resident A but did not provide further details regarding the incident.

Danette Young stated she spoke with Adonis Sokamte sr. who stated he had been in the laundry room at the time of the incident She stated Resident A was already in bed upon her arrival, appeared to be sleeping, and did not exhibit any visible concerns. Danette Young stated Adonis Sokamte Sr. did not provide detailed information regarding the incident, but indicated he was not directly involved, as he had been in the laundry room.

Danette Young stated Kristina Faust also did not provide detailed explanation of how the incident occurred. She further stated she did not recall any information related to Miralax caps specifically. Danette Young stated Adonis Sokamte Sr.'s communication can be unclear due to French being his primarily language; however, she stated no concerns regarding his care of residents.

On 03/10/2026, I interviewed the licensee designee, Harry Gross, who stated he agreed with the findings. He stated he did not believe Adonis Sokamte Sr. would engage in that type of behavior towards residents.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.</b>

<b>ANALYSIS:</b>	<p>Based on my investigation, which included interviews with direct care staff, Kristina Faust, Adonis Sokamte Sr, and Danette Faust, there is insufficient evidence supporting Adonis Sokamte Sr. struck Resident A on or around 03/01/2026.</p> <p>Kristina Faust stated observing Adonis Sokamte Sr. make contact with Resident A's head; however, she described the contact as a "tap" intended to redirect behavior and did not observe any resulting injury. Adonis Sokamte Sr. denied striking Resident A and Danette Young was not present during the incident and was unable to provide corroborating information.</p> <p>Additionally, no visible injuries to Resident A were reported or observed following the alleged incident. Statements obtained during the investigation were inconsistent and did not provide sufficient corroboration to support that an intentional act of mistreatment occurred as defined by the rule.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS**

**INVESTIGATION:** I conducted an unannounced onsite inspection on 03/19/2026 relating to the above allegations. Upon attempting to exit the facility, I observed the exterior door did not unlock without entering a code into a keypad. Direct care staff, Samone Gale, stated that the facility's exterior doors are kept locked and require a code to be entered into a keypad to open. She stated that the keypads are installed on all exterior doors to prevent Resident A from eloping.

I inquired whether the doors were connected to the fire alarm system. Samone Gale stated they were not. She further stated that a door separating the hallway containing resident bedrooms from the remainder of the home would close when the alarm was activated. She stated some residents have knowledge of the door codes. I also observed a keypad installed on the outside of the facility's front door.

Following the inspection, licensee designee, Harry Gross, contacted me regarding the keypad system. Contrary to staff's statements, he reported that the doors are connected to the facility's alarm system and would automatically unlock upon activation of the fire alarms. I informed Harry Gross that locking against egress is not permitted unless an approved variance is in place, and that the locking mechanisms needed to be disengaged immediately and may need to be removed if a variance is not granted.

On 03/22/2026, Harry Gross submitted a variance request to allow the facility's exterior doors be lock against egress.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (b) Exercise individual constitutional rights including right to vote, right to practice religion of choice, freedom of movement, and freedom of association.</b>
<b>ANALYSIS:</b>	During an unannounced inspection on 03/19/2026, I observed the facility's exterior doors were equipped with keypad locking mechanisms that required a code to exit. This configuration restricts residents' ability to freely exit the facility; therefore, the licensee is not ensuring residents' right to freedom of movement, as required.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.725</b>	<b>Means of egress.</b>
	<b>(3) Doors that form a part of a required means of egress must be equipped with positive-latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.</b>
<b>ANALYSIS:</b>	On 03/19/2026, I observed all exterior doors were equipped with keypad locking mechanisms that required entry of a code to exit. These doors were locked against egress and did not provide immediate, unobstructed exit as required for a means of egress.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 03/19/2026, I conducted my exit conference with the licensee designee, Harry Gross. He agreed with my findings regarding the original allegations. He stated the keypad locking mechanisms were placed on the exterior doors as an additional safety measure for Resident A. He stated this was approved by Resident A's local community mental health agency. Harry Gross agreed to submit a variance request, which he did on 03/22/2026; however, as of the date of this report, a variance has not been approved by the Department.

**IV. RECOMMENDATION**

Upon receipt of an acceptable corrective action plan, I recommend no change in the current license status.

*Cathy Cushman*

03/27/2026

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Cathy Cushman  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

03/27/2026

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Dawn N. Timm  
Area Manager

Date