GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 6, 2021

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AL410289728
Investigation #: 2021A0350042
InterActions Residential Treatment

Dear Mrs. Kross:

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 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL410289728
Investigation #:	2021A0350042
Complaint Receipt Date:	06/18/2021
Investigation Initiation Date:	06/22/2021
Report Due Date:	07/18/2021
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Anna Sundberg
Licensee Designee:	Jessica Kross
Name of Facility:	InterActions Residential Treatment
Facility Address:	300 68th St. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 493-6013
Original Issuance Date:	09/15/2008
License Status:	REGULAR
Effective Date:	03/15/2021
Expiration Date:	03/14/2023
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/7/2021, staff member Yvette Navarrette pushed Resident A.	Yes
On 6/7/2021, staff member Yvette Navarrette cussed at Resident A.	Yes

III. METHODOLOGY

06/18/2021	Special Investigation Intake 2021A0350042
06/22/2021	Special Investigation Initiated - Telephone I called the facility and spoke with Resident A
06/22/2021	Contact - Telephone call made I spoke with Taylor Russell, staff member
06/22/2021	Contact - Telephone call made I spoke with Elizabeth Darling, staff member
06/22/2021	Contact - Telephone call made I spoke with Cody Wright, supervisor
06/22/2021	Contact - Telephone call made I spoke with Candy McKenney, Senior Residential Manager
06/22/2021	Contact - Document Received I received two emails from Ms. McKenney
06/23/2021	Contact - Telephone call made I spoke with Yvette Navarrette, staff member
07/01/2021	Exit conference – Held with Jessica Kross, Licensee Designee

ALLEGATION: On 6/7/2021, staff member Yvette Navarrette pushed Resident A.

INVESTIGATION: On 06/22/2021, I called InterActions Residential Treatment and asked to speak with Resident A and a staff member got her on the phone. I asked Resident A about this incident and she reported that she went up to her (Yvette Navarrette, Direct Care Worker) and Ms. Navarrette “kind of like pushed me off of her.” I asked Resident A if she was harmed in this incident and she said no; and

added that Ms. Navarrette was not being aggressive; she was just getting Resident A off of herself to protect herself from potential harm.

On 06/22/2021, I called and spoke with Taylor Russell, Direct Care Worker (DCW) and she said she observed this incident. Ms. Taylor informed me that Resident A and another resident were arguing and fighting, and Ms. Navarrette intervened. Ms. Russell said that Resident A pushed Ms. Navarrette into the medication room door, and Ms. Navarrette pushed Resident A in return, and Resident A hit the wall and fell. Ms. Russell told me that Resident A was not injured from this. Ms. Russell stated that Ms. Navarrette later told Ms. Russell, “She’s lucky I didn’t do more.” Ms. Russell reported that Elizabeth Darling, Medication Technician, also witnessed this incident. Ms. Russell also said that she reported all of this to her supervisor, Cody Wright.

On 06/22/2021, I called and spoke with Elizabeth Darling, who stated that she witnessed this incident. Ms. Darling said that Resident A was attacked by Resident B, and that she, Ms. Darling, got Resident B to go into her room to separate her from Resident A. Ms. Darling reported that then Resident A went to retaliate against Resident B, but since she couldn’t get to her, she became aggressive towards Ms. Navarrette by first throwing shoes at her then by trying to hit her. Ms. Darling informed me that during this altercation Ms. Navarrette “bumped” Resident A away from her but then shoved Resident A with her “full body” using both hands and Resident A hit the door frame behind her and fell. Ms. Darling said she checked Resident A for injuries and found a bump on her head.

On 06/22/2021, I received a call from Candy McKenney, Senior Residential Manager. Ms. McKenney informed me that she spoke with Ms. Russell and Ms. Darling and their stories were inconsistent, and that Ms. Darling had been making allegations about other staff members because she wants to “shut the program down.” Ms. McKenney reported that Ms. Navarrette has been working there for about 10 years and does not have a history of using inappropriate behavior or making inappropriate comments. Ms. McKenney told me that she also spoke with Resident A who admitted to attacking Ms. Navarrette and that Ms. Navarrette pushed her during their altercation. Ms. McKenney said that Resident A told her she tripped over Resident B while they were fighting; and Ms. McKenney said that Resident A may have gotten the bump on her head from that. Ms. McKenney stated that she found it odd that Resident A did not mention any of this to Cody Wright, the home’s supervisor, or to her therapist. Additionally, Ms. McKenney said it was strange that neither Ms. Russell nor Ms. Darling wrote about either of these incidents (between Resident A and Resident B or between Resident A and Ms. Navarrette) in the staff notes.

On 06/22/2021, I received a couple of emails from Ms. McKenney with the following documents attached: Account of Incident, Incident Report, and Shift Note.

On 06/23/2021, I reviewed the above-mentioned documents. Excerpts from the Shift Note, written by Taylor Russell on 06/07, state:

'(Resident A) went into the bathroom and started to head bang, when staff approached her, she began to yell "get away from me." Staff Yvette and Staff Liz decided to give her space. (Resident A) exited the bathroom and went up to staff Yvette and took both of her shoes off and threw them induvial at Staff Yvette. (Resident A) then started yelling at Staff Taylor "You're a bitch." Staff Taylor prompted (Resident A) to go use coping skills and walk away. (Resident A) went out to the courtyard with her music to walk around when a (Resident B) followed (Resident A) to the courtyard (Resident A) fell to the ground and ended up taking the (Resident B) to the ground with her. (Resident A) then got punched in the face multiple times and her hair pulled. Staff were able to intervene. (Resident A) became upset when the (Resident B) finally got up and (Resident A) was yelling "I hope your mom dies" and then (Resident B) picked up (Resident A's) headphones and broke them into pieces. (Resident A) then went into the hallway where the (Resident B) was directed and attempted to go after the (Resident B). Staff redirected (Resident A) and Cody came out onto the unit and (Resident A) was still agitated. (Resident A) talked to supervisor Cody and became calm after he left the unit. (Resident A) played card games with staff and (Resident B) before lunch. (Resident A) turned her shift around. No further concerns.'

The Incident Report, also written by Ms. Russell, includes the information above, and adds, *'(Resident A) shoved Staff Yvette into the Med Room wall and Staff Yvette shoved (Resident A) into the wall between room 104...'.*

Below are some of the notes taken from The Accounts of Incident, which was generated by Ms. McKenney as part of her internal investigation:

(Resident A): *On June 17, 2021…Supervisors Cody and Trechaun met with (Resident A)…(Resident A) was asked to recount events that happened on June 7, 2021. (Resident A) shared that her and a female (Resident B) had gotten into a fight in the courtyard because (Resident B) had broken her headphones. (Resident A) continued saying that she went inside, and (Resident B) followed her into the hall…with intentions of harming (Resident A). (Resident A) stated that staff Taylor R. was near by and watched (Resident B) walk up to (Resident A) as she prompted (Resident B) to make better decisions but did not make any attempt to step in between the two ladies until after (Resident B) began hitting her again. (Resident A) expressed extreme frustration with this AEB screaming that staff Taylor could have prevented the event or protected her better. When asked if there were any other staff involved in the event, she said that it was possible that staff Elizabeth D. was present, but she was not entirely sure. …(Resident A) said that she remembered that she was upset with staff Yvette N. on June 7, 2021 and was throwing shoes at her prior to the fight. She also said that after the fight with (Resident B), she redirected her anger towards staff Yvette N. and began shoving her. She then said that staff Yvette N. pushed her back and (Resident A) said that she tripped and fell over either (Resident B) or Liz but can't remember and hit her head on the wall. When asked to clarify if staff Yvette N. was blocking (Resident A's) shoves and if she lost her balance, (Resident A) said "no, she actually pushed me" and showed a*

two-hand push at shoulder height. (Resident A) said that she had pushed staff Yvette N. first and appeared to not be bothered by staff Yvette's response AEB shrugging her shoulders and saying, "I guess I pushed her first so…"

Yvette N.: *On June 17, 2021…Clinical Manager Candy and Supervisor Trechaun called staff Yvette N. to discuss the alleged events on June 7, 2021. Staff Yvette shared it had been a busy shift due to having 3 staff on the unit and (Resident A) having outbursts and headbanging. She stated that (Resident A) had been agitated with Yvette and was throwing shoes at her to which Yvette did not respond to. She stated that (Resident A) was prompted by another staff to go out into the courtyard and listen to her music as a coping skill to which (Resident A) agreed. During this time, Yvette N. stated that she went back towards the kitchen and could hear screaming in the courtyard, so she went out to check on the residents. She noted that (Resident A) and (Resident B) were on the ground fighting and staff were present to try to break up the fight and did not say if she went to offer additional help. When the residents came back inside, she noted that (Resident A) was still looking to go after resident (Resident B) and her and other staff were trying to de-escalate the situation. Yvette said she stepped in between (Resident A) and (Resident B) when resident (Resident A) turned her frustrations back to staff Yvette and began pushing her..." Staff Yvette denies pushing (Resident A) and noted that she has been with Pine Rest for about 10 years and has never put her hands on a resident nor would she ever do that…Staff Yvette was informed that there will be an investigation of this alleged event and would be moved to Sequoia until the investigation is completed.*

Taylor R.: *On June 17, 2021…Supervisors Cody and Trechaun as well as Clinical Manager Candy spoke with staff Taylor R about the alleged events on June 7, 2021. When asked to recount the events, she shared that resident (Resident A) was agitated at the start of the shift and was making rude and provoking comments towards (Resident B) and staff Yvette N. Resident (Resident A) began throwing her shoes at staff Yvette N. which upset (Resident B)…Staff Taylor R. said that she had prompted resident (Resident A) to use her coping skills in the courtyard to which resident (Resident A) agreed. When she went into the courtyard, staff Taylor R. noted that staff Yvette was standing by room 109 and watched (Resident B) walk out into the courtyard after resident (Resident A). Staff Taylor R. emphasized that her and staff Elizabeth D. went out with (Resident B) and (Resident A) in anticipation of (Resident B) attempting to assault resident (Resident A) but staff Yvette "just watched [(Resident B) go out there and didn't try to stop her."...As staff Taylor continued, she said that (Resident A) and (Resident B) got into a verbal altercation and (Resident B) grabbed (Resident A's) headphones breaking them…when asked if there was a physical altercation with (Resident A) and (Resident B) inside, Taylor said (Resident B) was outside when (Resident A) came inside…Staff Taylor continued stating that (Resident B) had finally been de-escalated and resident (Resident A) was still agitated and turned this energy towards staff Yvette. She said that (Resident A) began shoving staff Yvette into the med room wall and staff Yvette pushed her back with her full body weight causing resident (Resident A) to fall*

backwards and hit her head on the wall. Staff Taylor reported that after the event Yvette sat with her at the table and said, "I could have done more."

Elizabeth D.: *On June 17, 2021…Clinical Manager Candy and Supervisor Trechaun spoke with staff Elizabeth D. regarding the alleged events on June 7, 2021…Elizabeth D. shared that (Resident A) had just ended a phone call and was upset by how the phone call went. She shared that she was in the med room and could hear (Resident A) directing her frustration towards (Resident B) stating, "I hope your mom dies". At this time, staff Yvette prompted (Resident A) for making these comments and (Resident A) was upset by this resulting in her throwing shoes at staff Yvette. Staff Yvette noted that the combination of hearing rude comments about her mother and seeing another staff being attacked caused (Resident B) to become increasingly agitated and (Resident B) went to her room to take off her glasses. Staff Elizabeth identified that this is a unique sign for (Resident B) that she is going to attack somebody and began to prompt (Resident B) to make good decisions and focus on her mom while validating her feelings. She continued saying that (Resident B) went out into the courtyard where (Resident A) was, stating that staff Yvette "just watched (Resident B) go into the courtyard with (Resident A) even though she knows that (Resident B) was going to attack (Resident A). Everyone knows when (Resident B) takes off her glasses, that means she is going to go after someone." She also included that she was the one that was supposed to stay inside and watch the residents but when she saw that staff Yvette was not going to go out with (Resident B) made the decision to follow (Resident B) into the courtyard. She continued describing that she had managed to de-escalate (Resident B) and get her into her room to avoid (Resident A) going after her again. Once (Resident B) was no longer involved, staff Elizabeth shared that (Resident A) turned her frustrations towards staff Yvette and began shoving her into the wall of the med room and staff Yvette pushed her back. She said that staff Yvette initially did a small push but when that did not stop (Resident A), staff Yvette used her full force and shoved resident (Resident A), causing her to fall back into the door frame of (Resident B) door and hit her head on the wall. Supervisor Trechaun asked staff Elizabeth to clarify that there were two shoves rather than one. Staff Elizabeth then showed how staff Yvette shoved resident (Resident A) the second time, showing arms cocked back and hands at shoulder height when arms were extended…She also reported that while in the med room, Yvette may have said "I could have done more…" Staff Elizabeth said (Resident A) had a huge knot on her head from being shoved. She said she completed a concussion protocol but did not need to contact nursing due to everything being "normal."*

On 06/23/2021, I called and spoke with Yvette Navarrette, who stated that they only had three staff members working the morning of this incident, which made them short-staffed. She reported that there were 11 or 12 residents at the facility at the time. Ms. Navarrette said that Resident A had been banging her head that morning and also got into a fight with Resident B. Ms. Navarrette informed me that while she was attempting to get Resident A and Resident B apart from each other, she used her body to "bump" Resident A, but said that she also pushed Resident A. When

asked if Resident A fell from being pushed, Ms. Navarrette told me she was not sure if she fell or not because “there was a lot going on”. Ms. Navarrette stated that she did not recall telling another staff member, “I could have done more,” pertaining to the way she handled Resident A that morning.

On 07/01/2021, I spoke with Jessica Kross, Licensee Designee. I informed Ms. Kross that I was citing violation of this rule and she stated that Ms. Navarrette would have to go through some retraining.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident A reported that Yvette Navarrette, staff member, “kind of like pushed me off of her” to protect herself. Staff members Taylor Russell and Elizabeth Darling stated that Ms. Navarrette shoved Resident A and that Resident A fell and hit her head against a wall, causing a bump. Ms. Navarrette admitted that she pushed Resident A in an attempt to separate Resident A and Resident B, who were fighting with each other, but stated she doesn’t remember if Resident A fell or not. Ms. Navarrette used excessive physical force against Resident A. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 6/7/2021, staff member Yvette Navarrette cussed at Resident A.

INVESTIGATION: On 06/22/2021, I called and spoke with Taylor Russell, Direct Care Worker (DCW) and she stated that she observed Ms. Navarrette interacting with Resident A while Resident A was upset and was displaying aggressive behaviors. Ms. Russell reported that during this incident, Ms. Navarrette said to Resident A, “Don’t you fucking touch me.”

On 06/22/2021, I called and spoke with Elizabeth Darling, who stated that she witnessed this incident. Ms. Darling reported that Resident A became aggressive towards Ms. Navarrette by first throwing shoes at her then by trying to hit her. Ms. Darling informed me that during this altercation Ms. Navarrette said to Resident A something like, “You’re lucky that’s all I did.”

On 06/22/2021, I received a couple of emails from Ms. McKenney with the following documents attached: Account of Incident, Incident Report, and Shift Note.

The Incident Report, also written by Ms. Russell, includes the information above, and adds, “(Resident A) shoved Staff Yvette into the Med Room wall and Staff Yvette shoved (Resident A) into the wall between room 104 and 105 stating ‘Don’t fucking touch me.’”

Below are some of the notes taken from The Accounts of Incident, which was generated by Ms. McKenney as part of her internal investigation:

(Resident A): *On June 17, 2021…Supervisors Cody and Trechaun met with (Resident A)…shared that staff Yvette said, “You’re lucky that I didn’t do something else” while raising a fist and did not remember Yvette using any profanity.*

Yvette N.: *On June 17, 2021…Clinical Manager Candy and Supervisor Trechaun called staff Yvette N…who said she stepped in between (Resident A) and (Resident B) when resident (Resident A) turned her frustrations back to staff Yvette and began pushing her to which staff Yvette responded by saying, “Keep your hands off of me.”*

Taylor R.: *On June 17, 2021…Supervisors Cody and Trechaun as well as Clinical Manager Candy spoke with staff Taylor R about the alleged events on June 7, 2021. Staff Taylor..reported…that staff Yvette said (to Resident A), “Don’t fucking touch me.”*

Elizabeth D.: *On June 17, 2021…Clinical Manager Candy and Supervisor Trechaun spoke with staff Elizabeth D. regarding the alleged events on June 7, 2021…Elizabeth D. shared that…She was unable to remember if staff Yvette said anything when she shoved resident (Resident A) but said, “maybe she said, ‘Don’t fucking touch me’ but I am not sure.”*

On 06/23/2021, I called and spoke with Yvette Navarrette, who stated Resident A had been banging her head that morning and also got into a fight with Resident B. Ms. Navarrette informed me that she “may have cussed at” Resident A because Resident A was throwing shoes at her.

On 07/01/2021, I spoke with Jessica Kross, Licensee Designee. I informed Ms. Kross that I was citing a violation of this rule and she stated that Ms. Navarrette would have to go through some retraining.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	Resident A reported that Ms. Navarrette said to her, "You're lucky that I didn't do something else." Staff member Taylor Russell heard Ms. Navarrette say to Resident A, "Don't you fucking touch me;" and staff member Elizabeth Darling heard Ms. Navarrette say to Resident A, "You're lucky that's all I did." Ms. Navarrette reported that she told Resident A, "Keep your hands off of me," and also said that she "may have" cussed at Resident A. Ms. Navarrette verbally abused Resident A by cussing at her and threatening. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this facility's license remain unchanged, and that this special investigation be closed.

July 01, 2021

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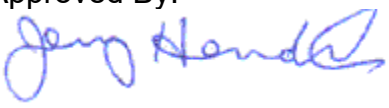
Ian Tschirhart Date
Licensing Consultant

Approved By:



July 6, 2021

_____

Jerry Hendrick
Area Manager

Date