GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2025

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

RE: License #: AL410289728
Investigation #: 2025A0583031
InterActions Residential Treatment

Dear Mrs. Kross:

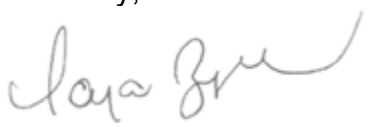
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
Report contains offensive language.

I. IDENTIFYING INFORMATION

License #:	AL410289728
Investigation #:	2025A0583031
Complaint Receipt Date:	04/02/2025
Investigation Initiation Date:	04/03/2025
Report Due Date:	05/02/2025
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Jessica Kross
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:	03/15/2025
Expiration Date:	03/14/2027
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Daniel Molero verbally mistreated Resident A and B.	Yes

III. METHODOLOGY

04/02/2025	Special Investigation Intake 2025A0583031
04/03/2025	Special Investigation Initiated - On Site
04/03/2025	APS Referral
04/09/2025	Exit Conference Candy McKenney Residential Manager

ALLEGATION: Staff Daniel Molero verbally mistreated Resident A and B.

INVESTIGATION: On 04/02/2025 the above complaint allegation was received from recipient rights via LARA-BCHS-Complaints. The complaint alleged that “on 03/22/2025, Daniel Molero, Staff member got into a verbal altercation with a peer of (Resident A)” and that “this verbal altercation was loud and littered with strong language”. The complaint further alleged that Resident A asked Mr. Molero "why are you doing this?" and Mr. Molero responded by stating, "shut the fuck up."

On 04/03/2025 I completed an unannounced onsite investigation at the facility and privately interviewed Supervisor Diane Salsbury and Resident A.

Ms. Salsbury stated that she worked at the facility on 03/22/2025. Ms. Salsbury stated that on that afternoon, staff Daniel Molero transported Resident A and Resident B to Walmart for “an outing”. Ms. Salsbury stated that after returning from the outing, she was assisting another resident in their bedroom. She stated that when she exited the bedroom, Mr. Molero requested to leave the facility because he needed a break. Ms. Salsbury stated that Mr. Molero reported that Resident B made sexually inappropriate remarks while at Walmart and continued to verbally mistreat Mr. Molero after returning to the facility. Ms. Salsbury stated that Mr. Molero said that Resident B called Mr. Molero a “fucking immigrant” and told Mr. Molero that Resident B “hopes his mother dies”. Mr. Salsbury stated that Mr. Molero acknowledged that he told Resident A to “shut up” after Resident A joined Resident B in verbally mistreating Mr. Molero. Ms. Salsbury stated that Mr. Molero was given a written reprimand for telling Resident A to “shut up”.

Resident A stated that on 03/22/2025 staff Daniel Molero and Brigitta Kessler transported Resident A and Resident B to Walmart for an outing. Resident A stated that while at Walmart, Mr. Molero grabbed Resident B by his neck and stabbed Resident B with a key. Resident A stated that when they arrived back to the facility, Mr. Molero yelled at Resident B and then proceeded to throw a bag of Tupperware at the wall. Resident A stated that Ms. Kessler observed Mr. Molero throw the bag of Tupperware at the wall. Resident A stated that she told Mr. Molero that his behavior was “uncalled for”. Resident A stated that Mr. Molero then told Resident A to, “shut the fuck up”. Resident A stated that this was the first time Mr. Molero has verbally mistreated her.

I requested to interview Resident B, however Resident B refused.

On 04/03/2025 I filed an Adult Protective Services complaint via telephone with Centralized Intake.

On 04/03/2025 I interviewed staff Bridgitta Kessler via telephone. Ms. Kessler stated that she worked at the facility on 03/22/2025 with staff Daniel Molero. Ms. Kessler stated that while at Walmart, Resident B said that he “likes white pussy” very loudly. Mr. Kessler stated that Mr. Molero appropriately told Resident B that “you shouldn’t say that” in public. She stated that she did not observe Mr. Molero grab Resident B or stab Resident B with a key. Ms. Kessler stated that right after Resident B’s inappropriate comment, they returned to the facility. Ms. Kessler stated that while at the facility, Resident A and Resident B were yelling at Mr. Molero. Ms. Kessler stated that during the incident, she observed Mr. Molero picking up Tupperware from his lunch box. Ms. Kessler stated that she was unsure if Mr. Molero dropped the Tupperware accidentally or threw it intentionally. Ms. Kessler stated that Mr. Molero became upset by Resident A and Resident B yelling at Mr. Molero and Mr. Molero retaliated by telling Resident A to “shut the fuck up”. Ms. Kessler stated that Mr. Molero then left the facility to take a break and did not return to the facility that night. Ms. Kessler stated that she has never observed Mr. Molero verbally or physically mistreat residents in the past.

On 04/03/2025 I interviewed staff Daniel Molero via telephone. Mr. Molero stated that he worked at the facility on 03/22/2025. Mr. Molero stated that during the shift Resident A and Resident B participated in an outing to Walmart. Mr. Molero stated that Resident B was in a good mood until he blurted out “pussy” while at Walmart. Mr. Molero stated that he verbally redirected Resident B for the inappropriate comment, and they returned to the facility. Mr. Molero stated that while at the facility, Resident B continued to display verbally inappropriate behaviors. Mr. Molero stated that Resident B said, “something about my mom dying”. Mr. Molero stated that he took offense to Resident B’s comment because Mr. Molero’s mother was in the Intensive Care Unit due to a recent surgery. Mr. Molero stated that during the incident, he dropped his lunch bag which contained plastic storage containers. Mr. Molero stated that he never threw the items but accidentally dropped them. Mr. Molero stated that he was upset regarding Resident B’s comment and asked to

leave the facility to take time and space for himself. Mr. Molero stated that he was granted time to leave the facility by his supervisor to decompress. Mr. Molero stated that just before he left, Resident A began yelling at Mr. Molero. Mr. Molero stated that he told Resident A to “shut up”. Mr. Molero admitted that his verbal comment to Resident A was not appropriate. Mr. Molero stated that he did not verbally mistreat Resident B in any manner.

On 04/09/2025 I completed an exit conference via telephone with residential manager Candy McKenney. Ms. McKenney stated that licensee designee Jessica Kross was out of the office for the remainder of week and Ms. McKenney is tasked with completing exit conferences in Ms. Kross’ absence. Ms. McKenney stated that the facility administration is already aware of the incident and Mr. Molero has acknowledged his role in verbally mistreating Resident A. Ms. McKenney stated that she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Staff Daniel Molero stated that on 03/22/2025, he told Resident A to “shut up”. Resident stated that on 03/22/2025, staff Daniel Molero told Resident A to “shut the fuck up”. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule; staff Daniel Molero verbally mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

04/09/2025

Toya Zylstra Date
Licensing Consultant

Approved By:

04/09/2025

Jerry Hendrick Date
Area Manager