GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4, 2025

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

RE: License #: AL410289728
Investigation #: 2025A0340047
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) 356-0100.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410289728
Investigation #:	2025A0340047
Complaint Receipt Date:	07/02/2025
Investigation Initiation Date:	07/02/2025
Report Due Date:	08/31/2025
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 Takeela Mapp attempted to punch Resident A.	Yes

III. METHODOLOGY

07/02/2025	Special Investigation Intake 2025A0340047
07/02/2025	APS Referral
07/02/2025	Special Investigation Initiated - Telephone Candy McKenney
07/09/2025	Inspection Completed On-site
07/29/2025	Inspection Completed On-site
07/30/2025	Contact - Telephone call made Staff Takeela Mapp
07/30/2025	Contact – Telephone call made Staff Ariane Lewis
07/30/2025	Exit Conference Candy McKenney

ALLEGATION: Staff Takeela Mapp attempted to punch Resident A.

INVESTIGATION: On July 2, 2025, a complaint was filed with the BCHS Online Complaints which stated that on 6/29/25, Resident A reported that Takeela Mapp attempted to “throw punches” at her. Ms. Mapp was terminated following the incident.

On July 2, 2025, the allegation was sent to Adult Protective Services.

On July 2, 2025, I contacted Administrator Candy McKenney. She was aware of the incident which occurred. Ms. McKenney confirmed that Ms. Mapp has been terminated. She stated Resident A was exhibiting behaviors and Ms. Mapp had taunted Resident A rather than attempt to help or redirect her. Ms. Mapp became verbally aggressive, inappropriate and even threatened Resident A.

Ms. McKenney sent an Incident Report (IR) which was filed regarding the events with Resident A which I received and reviewed. It was written by staff Sabrina Lopez-Dahike on 6/29/25. It stated that Resident A began to bang her head on the dining room table. Staff Lopez-Dahike attempted to deescalate her, but she became irritated with staff Takeela Mapp, calling her a “bitch” and began to spit at Ms. Mapp. Ms. Mapp responded, “Do not spit on me”. Resident A then said, “What are you going to do about it (N-word)?” Ms. Mapp responded, “I’ll show you why I’m a (N-word)”. Resident A yelled “Fuck you!” and Ms. Mapp blew Resident A a kiss. Resident A continued to spit at Ms. Mapp, all while Ms. Lopez-Dahike continued to redirect and deescalate Resident A using a foam board to keep Resident A from hitting her head. Resident A got up and started to walk toward Ms. Mapp. Ms. Lopez-Dahike stood between Resident A and Ms. Mapp. Ms. Mapp put up her fists and took a step forward and said “you know what bitch, I’m not the fucking one, I’m gonna show you know spit”. Resident A got upset and yelled at Ms. Mapp that staff is supposed to care about her. Ms. Mapp walked away as Pine Rest security walked in. Resident A became assaultive and was placed in restraint by security. Ms. Mapp came up to assist but security told her to not to assist because Ms. Mapp had screamed at Resident A, “I’ll help you with your fucking coping skills but I don’t assault shit and spitting is assault”.

Kent County Sheriff’s Dept was called for additional assistance. Resident A was taken by Kent County Sheriff’s Dept to Trinity Health ER. She returned to the program after being evaluated. Resident A will follow up with her psychiatrist for a medication review on 7/18/25 and Ms. Mapp was terminated following the incident.

Also included were statements from other staff participants in the incident.

A statement from security officer Andrew Gawrych states he arrived at Interactions and witnessed Ms. Mapp yelling and arguing with Resident A. The statement read, “I tried to separate the two of them which worked for a moment. We ended up having to restrain (Resident A) due to attempting to assault staff.” While (Resident A) was in the hold, Ms. Mapp got down on their knees and began arguing with (Resident A) right in her face. Resident A was using racial slurs. Ms. Mapp smothered (Resident A’s) face with the blocking pads. They pressed the blocking pad down onto (Resident A’s) face. Ms. Mapp was then separated from (Resident A) while she was restrained.”

A statement from staff Ariane Lewis states Resident A spit at Ms. Mapp and Ms. Mapp said, “I’m not like other staff so don’t spit at me”. The statement indicated Resident A spit on her a couple more times and Ms. Mapp continued to say things to Resident A including she will “beat (Resident A’s) ass”. Resident A asked Ms. Mapp why she would work here if she would “beat her ass”. Ms. Mapp said she would help her with her goals, but she was not coming to work to be assaulted and if she kept spitting at her she was “going to beat her fucking ass”. Ms. Mapp was pacing back and forth, and Resident A was “worked up”. Security separated the two, but Ms. Mapp continued to antagonize Resident A. When Resident A “charged at her”

Ms. Mapp “took a boxing stance and put her hands up in a fist”. Security then placed Resident A in a hold and kept Ms. Mapp away from her.

Ms. McKenney also sent Resident A’s Assessment Plan which I reviewed on this date. It was signed by Designee Jessica Kross on 5/28/2025. Under “Controls Aggressive Behavior” it states: “No, (Resident A) has a history of engaging in aggressive behaviors when staff intervene to prevent her from engaging in self-injurious behaviors; however, (Resident A) has not been reported to engage in self-injurious behavior in at least 6 months. See BSP for further assistance in this area.”

I asked Ms. McKenney about the interventions with the pads when Resident A head bangs and she stated they are standard protocol, and not specifically stated in Resident A’s BSP. It is also protocol for residents to be sent out to the ER if they have exhibited the head banging behavior for an extended period of time or if there are signs of concern after staff perform a concussion assessment.

On July 7, 2025, I attempted to interview Resident A but she was not home at the time of my inspection.

On July 29, 2025, I conducted an unannounced home inspection. I first spoke with Ms. McKenney who informed me that Resident A was having a difficult day but was home and in her room. Ms. McKenney and nurse Eric Lund took me to Resident A’s room where I saw her rocking back and forth on her bed. Mr. Lund introduced me and informed Resident A I was there to visit with her. I said hello to Resident A and observed her shake her head back and forth, indicating she did not want to meet with me. Mr. Lund asked again if she would speak with me and again she shook her head back and forth, indicating a negative response.

On July 30, 2025, I contacted Ms. Mapp. I informed her who I was and the reason for my call. I asked if she would give me her account of what happened at Interactions on 6/29/25 with Resident A. Ms. Mapp stated she had already spoke to someone about this and abruptly ended the phone conversation.

On July 30, 2025, I contacted Ms. Lewis. I explained the reason for my call and asked for her account of what had occurred between Ms. Mapp and Resident A. Ms. Lewis’s account was consistent her statement provided on the day of the incident.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	The allegation was made that staff Takeela Mapp attempted to punch Resident A. Witness statements provided by staff Lopez-Dahike, Gawrych, and Lewis confirm that Resident A was exhibiting self-harming behaviors and Ms. Mapp did verbally antagonize, verbally assault and then did physically assault Resident A by taking the foam pads used to prevent Resident A from banging her head against a hard surface, and "smothered her face" with them. Ms. Mapp did not provide comment for this investigation and has been terminated. There is a preponderance of evidence that a rule violation did occur.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 30, 2025, I contacted Ms. McKenney. I discussed with her my findings of a rule violation which she understood and agreed with since it was decided to terminate Ms. Mapp. I asked for a Corrective Action Plan which she agreed to send. Ms. McKenney had no further questions.

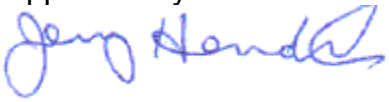
IV. RECOMMENDATION

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

August 4, 2025

Rebecca Piccard — Date
Licensing Consultant

Approved By:



August 4, 2025

Jerry Hendrick — Date
Area Manager