GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 27, 2023

Ramon Beltran
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390406165
Investigation #: 2023A1024019
Beacon Home at Richland

Dear Mr. Beltran:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 3/22/2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406165
Investigation #:	2023A1024019
Complaint Receipt Date:	01/31/2023
Investigation Initiation Date:	02/03/2023
Report Due Date:	04/01/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Richland
Facility Address:	9445 N. 24th St. Richland, MI 49083
Facility Telephone #:	(269) 488-0024
Original Issuance Date:	01/11/2021
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Venna Willemsen does not respect resident boundaries and forces residents to hug and kiss her.	Yes

III. METHODOLOGY

01/31/2023	Special Investigation Intake 2023A1024019
01/31/2023	APS Referral-APS already involved; no referral needed.
02/03/2023	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Suzie Suchyta
02/06/2023	Contact - Telephone call made with APS Specialist Gene Coulter
02/15/2023	Inspection Completed On-site with home manager Angie Sutton, direct care staff members Jennifer Traxler and Residents A, B, and D
03/22/2023	Exit Conference with licensee designee Ramon Beltran
03/22/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Direct care staff member Venna Willemsen does not respect resident boundaries and forces residents to hug and kiss her.

INVESTIGATION:

On 1/31/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged that direct care staff member Venna Willemsen does not respect resident boundaries and forces residents to hug and kiss her.

On 2/3/2023, I conducted an interview with RRO Suzie Suchyta who stated she is also investigating this allegation and found substantial evidence to support the allegation. Ms. Suchyta stated four residents in the home verbally reported to her that inappropriate physical contact was made by direct care staff Ms. Willemsen. Resident A reported to Ms. Suchyta that Ms. Willemsen forced him to hug her even though he said he did not want a hug and then Ms. Willemsen pinched his bottom. Ms. Suchyta further stated Resident B reported Ms. Willemsen forcefully kissed him on his face, and he did not like it. Ms. Suchyta stated Resident C also reported he was forced by Ms. Willemsen to hug

her, and he did not like it therefore he retreated to his bedroom for the remainder of the day. Ms. Suchyta stated Resident D also reported he was forced to hug Ms. Willemsen. Ms. Suchyta stated during her investigation, Ms. Willemsen grabbed and hugged Ms. Suchyta without consent during an interview and Ms. Willemsen had to be prompted and redirected to keep healthy boundaries with her.

On 2/6/2023, I conducted an interview with APS Specialist Gene Coulter who stated he also investigated this allegation and found substantial evidence to support the allegation. Mr. Coulter stated during his investigation, Ms. Willemsen did not understand the meaning of having healthy boundaries and could not comprehend when Mr. Coulter attempted to explain why it is important to respect resident boundaries. Mr. Coulter stated Ms. Willemsen stated she is a “motherly figure” and likes to give hugs and kisses to people with whom she interacts. Mr. Coulter stated all residents in the home reported to him that Ms. Willemsen does not respect their boundaries.

On 2/15/2023, I conducted an onsite investigation at the facility with direct care staff members Jennifer Traxler and Angie Sutton. Ms. Traxler stated she has worked with Ms. Willemsen in the past and has observed Ms. Willemsen force residents to hug her even when they express to her that they do not want to be hugged. Ms. Traxler stated recently she heard Ms. Willemsen repeatedly asked Resident A and Resident B to give her a hug and heard the residents inform her that they did not want to be touched however Ms. Willemsen continued to make attempts to give the residents a hug. Ms. Traxler stated she also observed Resident D ask Ms. Willemsen to stop staring at him because it was making him uncomfortable, and Ms. Willemsen disregarded his request and stated to Resident D “you know you love” even after Resident D appeared to be getting frustrated.

Ms. Sutton stated she has never worked with Ms. Willemsen however the residents in the home have all reported to her that Ms. Willemsen forces the residents to hug her. Ms. Sutton stated Resident A also reported to her that Ms. Willemsen pinched him on his bottom after he asked her not to touch him. Ms. Sutton stated Ms. Willemsen denied pinching Resident A on his bottom. Ms. Sutton stated prior to Resident A reporting this to her, Resident B approached her and stated to her that Ms. Willemsen was trying to give him kisses on his cheek when he asked her not to do so.

While at the facility, I also interviewed Residents A, B, and D who all stated within the past month Ms. Willemsen has made them feel uncomfortable by having physical contact with them. Resident A stated on two separate occasions, Ms. Willemsen gave him hugs after he asked her not to. Resident A stated when he tried to walk away, Ms. Willemsen pinched him on the bottom. Resident A stated he “hates” germs and does not like for people to touch him.

Resident B stated while he was sitting at the dining room table, Ms. Willemsen kissed him on the face near his lips. Resident B stated when he asked her to stop, she discontinued touching him as he requested however wanted a hug.

Resident D stated while he was eating, Ms. Willemsen continued to stare at him and when he asked her to stop staring at him, she made “weird statements” to him such as “you are going to miss me when I’m gone.” Resident D further stated he is “not a hugger” and Ms. Willemsen repeatedly makes attempts to give him hugs when he asks her not to.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Jennifer Traxler, Angie Sutton, RRO Suzie Suchyta, APS Specialist Gene Coulter, Residents A, B, and D there is evidence direct care staff member Venna Willemsen does not respect resident boundaries and forces residents to hug and kiss her. According to Ms. Traxler she has observed Ms. Willemsen force residents to hug her even when they express to her that they do not want to be hugged. Ms. Suchyta stated four residents made complaints to her regarding Ms. Willemsen displaying inappropriate boundaries which includes forcing residents to hug her, kissing a resident on the face, and pinching a resident on their bottom. Ms. Suchyta also stated Ms. Willemsen demonstrated inappropriate boundaries towards her during an interview and had to be redirected. Mr. Coulter also stated during his investigation, Ms. Willemsen did not understand the meaning of having healthy boundaries and could not comprehend when Mr. Coulter attempted to explain why it is important to respect resident boundaries. Residents A, B, and D all stated that Ms. Willemsen has made them feel uncomfortable by touching them after being asked not to do so. Ms. Willemsen has not treated the residents with consideration and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/22/2023, I conducted an exit conference with Mr. Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions or make comments.

ON 3/22/2023, I received and approve an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore, I recommend the current license status remain unchanged.

Ondrea Johnson — 3/22/2023

Ondrea Johnson
Licensing Consultant
Date

Approved By:

03/27/2023

Dawn N. Timm
Area Manager
Date