GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2026

Benjamin Visel
Visel AFC, Inc.
6565 Whitneyville Ave. SE
Alto, MI 49302

RE: License #: AM410401224
Investigation #: 2026A0467044
Visel Hilltop AFC

Dear Mr. Visel:

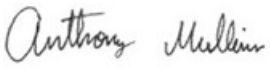
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days.

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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410401224
Investigation #:	2026A0467044
Complaint Receipt Date:	07/17/2026
Investigation Initiation Date:	07/22/2026
Report Due Date:	09/15/2026
Licensee Name:	Visel AFC, Inc.
Licensee Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Licensee Telephone #:	(616) 893-6613
Administrator:	Benjamin Visel
Licensee Designee:	Benjamin Visel
Name of Facility:	Visel Hilltop AFC
Facility Address:	6565 Whitneyville Ave. SE Alto, MI 49302
Facility Telephone #:	(616) 868-7478
Original Issuance Date:	06/25/2020
License Status:	REGULAR
Effective Date:	02/24/2026
Expiration Date:	02/23/2028
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 07/16/26, Resident A was in the community without staff supervision.	Yes
Additional Finding	Yes

III. METHODOLOGY

07/17/2026	Special Investigation Intake 2026A0467044
07/21/2026	APS Referral Complaint received from Kent County APS
07/22/2026	Special Investigation Initiated - On Site
07/29/2026	Contact – telephone call made to AFC staff member Abygayle Brown.
08/03/2026	Telephone call made to licensee designee, Ben Visel
08/12/2026	Exit conference with Ben Visel

ALLEGATION: On 07/16/26, Resident A was in the community without staff supervision.

INVESTIGATION: On 07/17/26, I received a complaint from Kent County Adult Protective Services (APS). The complaint alleged that on 07/16/26, Resident A was seen alone at the Greenwood Psychiatric Clinic (Network 180) around 4:00pm. It was unclear how or why Resident A arrived at the clinic, as she did not have a scheduled appointment. AFC staff member Brenda Overstreet was contacted by phone and stated she was unaware that Resident A had left the home. It is believed Resident A may have left the home around 2:00pm.

On 07/22/26, I conducted an unannounced onsite investigation at the home. Upon arrival, staff member Brenda Overstreet allowed entry into the home and agreed to discuss the allegation. Ms. Overstreet confirmed that Resident A was at Network 180 without staff supervision on the afternoon of 07/16/26. Ms. Overstreet explained that earlier that day, she transported Resident A to an eye appointment at 11:00am and returned her to the home at approximately 1:15pm. After dropping her off, Ms. Overstreet left the home around 1:30pm, as staff member Abygayle Brown was scheduled to work. Ms. Overstreet reported that when she left at 1:30pm, Resident A was sitting in a chair outside near the garage.

Between 3:00pm and 3:15pm, Ms. Overstreet received a call from Network 180 staff informing her that Resident A had arrived at the clinic without supervision and

without a scheduled appointment. Network 180 staff also informed her that Resident A needs transportation back to the home. Ms. Overstreet stated she believed Resident A may have arrived via the bus that picks up residents for Day Program, but that Resident A may have used an Uber that was coming to the home to transport a different resident. Ms. Overstreet was unable to confirm exactly how Resident A left the home without staff knowledge. Ms. Overstreet confirmed that Resident A is not allowed unsupervised community time. She further stated that Resident A did not sustain any injuries while unsupervised in the community. While onsite, I reviewed Resident A's assessment plan, which also states that staff must accompany her when she is in the community.

On 07/30/26, I spoke to staff member Abygayle Brown via phone regarding the allegation. Ms. Brown confirmed that on 07/16/26, Resident A left the home unsupervised and somehow traveled to Network 180 without her knowledge. Ms. Brown stated she is unsure how Resident A got to Network 180 but noted the Hope Network Day Program bus arrived at the home between 3:00pm and 3:30pm to drop off residents. During that time, an Uber arrived to transport another resident to an appointment.

Ms. Brown reported that while both vehicles were at the home, she observed Resident A sitting outside in a chair between the house and the garage, as she often does. Ms. Brown stated she watched both the Uber and bus depart and noted that Resident A was still sitting in the chair. As a result, she does not know how Resident A was able to leave the home and get to Network 180.

Approximately 30 to 45 minutes after the vehicles left, Ms. Brown was notified by her colleague that Resident A left the home and was at Network 180. Ms. Brown confirmed that Ms. Overstreet picked up Resident A and returned her to the home, and that no issues occurred while Resident A was unsupervised in the community. Ms. Brown acknowledged that Resident A is not permitted to be in the community without staff supervision.

Ms. Brown stated she has been employed at the home for about one month and this is the only instance in which a resident left or was picked up without her knowledge. She reported that she has discussed preventative measures with licensee designee Ben Visel, and with Ms. Overstreet, including maintaining closer supervision of Resident A and checking on her more often.

On 08/03/26, I spoke to licensee designee Ben Visel via phone. I discussed the allegations as well as the information relayed to me from the two staff members, Ms. Overstreet and Ms. Brown. Mr. Visel confirmed that he doesn't know how or when Resident A was transported to Network 180. Mr. Visel stated that his outdoor camera doesn't pick up everything. However, on the day in question, Resident A can be seen on the driveway camera at 1:42pm and again at 5:08pm, which was after she was returned home by Ms. Overstreet. Therefore, it is believed that Resident A left the home sometime after 1:42pm. Mr. Visel stated that Network 180 staff

schedules Uber's appointment for clients to transport them to their clinic. Mr. Visel shared that there have been times when Network 180 staff have booked an Uber for a client for a specific time, and after being picked up, another Uber has arrived to pick-up the same resident, leading to confusion. Mr. Visel shared that the confusion is on Network 180's end as opposed to the home's. Mr. Visel explained that Resident A has lived at the home for several years and this is the only time that an incident like this has occurred with her. Mr. Visel requested additional time to communicate with staff at Network 180 in attempt to get details of how this occurred.

On 08/12/26, I conducted an exit conference with licensee designee, Ben Visel. He shared that he has reached out to Network 180 to obtain additional information. However, his attempt was unsuccessful. As of the conclusion of this report, it is still unknown exactly who transported Resident A to Network 180 without staff supervision on 07/16/26. I explained to Mr. Visel that due to Resident A being in the community without staff supervision, this is a violation of licensing rule 671(4). Mr. Visel understood and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	AFC staff members Ms. Overstreet and Ms. Brown both confirmed that Resident A is required to have staff supervision while in the community. However, on 07/16/26, she was able to leave the home without staff knowledge and make it to Network 180 before staff knew of her whereabouts. Therefore, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, I requested to review Resident A's assessment plan. While doing so, I noticed that the assessment plan was last signed by Resident A on 07/13/25, which was 9 days outdated. Per licensing rules, this form is required to be updated annually.

On 08/12/26 I conducted an exit conference with licensee designee, Ben Visel. He was informed of the investigative findings and agreed to complete a Corrective Action Plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's assessment plan has not been updated since 07/13/25. Therefore, there is a preponderance of evidence to support this applicable licensing rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Anthony Mullins 08/12/2026

Anthony Mullins Date
Licensing Consultant

Approved By:

Jerry Hendrick 08/12/2026

Jerry Hendrick Date
Area Manager