GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

WOLF RIVERS ASSISTED LIVING FACILITY, LLC
Stephanie Nelson
118 W Adams St
THREE RIVERS, MI 49093

RE: License #: AS750418830
Investigation #: 2026A1030038
Wolf Rivers

Dear Stephanie Nelson:

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 feel free to 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,

Nile Khabeiry, 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 #:	AS750418830
Investigation #:	2026A1030038
Complaint Receipt Date:	06/15/2026
Investigation Initiation Date:	06/16/2026
Report Due Date:	08/14/2026
Licensee Name:	WOLF RIVERS ASSISTED LIVING FACILITY, LLC
Licensee Address:	118 W Adams St THREE RIVERS, MI 49093
Licensee Telephone #:	(269) 625-3228
Administrator:	Stephanie Nelson
Licensee Designee:	Stephanie Nelson
Name of Facility:	Wolf Rivers
Facility Address:	118 W Adams St Three Rivers, MI 49093
Facility Telephone #:	(269) 625-5565
Original Issuance Date:	01/30/2025
License Status:	REGULAR
Effective Date:	07/30/2025
Expiration Date:	07/29/2027
Capacity:	6
Program Type:	MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was physically restrained by staff without an order from a licensed health care professional.	Yes
Additional Findings	No

II. METHODOLOGY

06/15/2026	Special Investigation Intake 2026A1030038
06/16/2026	Special Investigation Initiated - Telephone Interview with referral source
06/16/2026	Contact - Telephone call made Interview with Resident A's legal guardian
06/17/2026	APS Referral Received and reviewed APS referral
06/18/2026	Inspection Completed On-site Interview with Stephanie Nelson
06/18/2026	Contact - Face to Face Interview with Erika Gross
6/18/2026	Contact – Document received Reviewed Resident A’s Assessment Plan
07/06/2026	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was physically restrained by staff without an order from a licensed health care professional.

INVESTIGATION:

On 6/16/26, I interviewed the referral source (RS) by phone. The RS reported he interviewed the facility owner, Stephanie Nelson and Resident A's legal guardian. The RS reported he attempted to interview Resident A but was unable due to his Dementia diagnosis. The RS reported that Ms. Nelson admitted to using a restraint on Resident A due to his assaultive behaviors. The RS reported there were no injuries to Resident A and that he is now residing with his legal guardian.

On 6/16/26, I interviewed Resident A's legal guardian by phone. Guardian A1 reported that she placed Resident A at the facility less than two weeks ago and informed Ms. Nelson of his diagnosis. Guardian A1 reported that Ms. Nelson also knew that he had a history of wandering off or trying to leave his home. Guardian A1 reported that Ms. Nelson texted her many times after he was placed at the facility about his behaviors and she would go to the facility to provide support for Resident A and the staff. Guardian A1 reported that she missed a text message on June 11th asking for her assistance but responded to the home as soon as she read the message and found Resident A tied to a chair with a Gait belt. Guardian A1 reported that she did not believe that was appropriate and never gave permission for Ms. Nelson to restrict his movement. Guardian A1 denied any injuries and indicated that Resident A was enrolled in hospice and lived with her now.

On 6/18/26, I interviewed Stephanie Nelson at the facility. Ms. Nelson reported she admitted Resident A to the facility on 6/3/26 and was informed of his diagnosis of Dementia but was informed that he was violent. Ms. Nelson reported that the behavioral problems began on the first day he moved into the facility and continued daily. Ms. Nelson reported that Resident A went into other residents' bedrooms and harassed them and would defecate on the floor and urinate in the sink. Ms. Nelson reported that Resident A assaulted the staff and her on several occasions. Ms. Nelson reported she completed daily incident reports and informed Resident A's legal guardian of his behavior. Ms. Nelson also reported that she helped enroll him in hospice services prior to him moving back in with his guardian.

Ms. Nelson reported that on 6/12/26 Resident A became verbally abusive towards her, the staff and aggressed towards Resident B. Ms. Nelson reported that they tried to redirect Resident A many times throughout the day, however he continued acting out verbally and trying to elope from the facility. Ms. Nelson reported that she texted Resident A's legal guardian early in the morning asking her to come to the home to help

settle Resident A down and she did not respond until about 2:00pm. Ms. Nelson also reported to the guardian that Resident A needed to be removed from the home as he needed a higher level of care which the facility could not provide. Ms. Nelson reported that Resident A punched direct care staff member Erika Gross when she tried to redirect him and grabbed Resident B's walker, so she believed she had no choice but to physically restrain him and grabbed his wrist and made him sit in a chair. Ms. Nelson reported that she and Ms. Gross had to physically manage him and used a gait belt to secure him to the chair. Ms. Nelson reported that Resident A then began spitting at her and head butted her in the mouth causing a fat lip. Ms. Nelson reported that during her time as an RN working at the hospital and nursing homes, they were able to physically restrain residents if they were in danger of harming themselves or other patients. Ms. Nelson was informed that restricting movement is not permitted unless she had an order from Resident A's doctor and she should have contacted emergency services and had Resident A transported to the nearest emergency department. Ms. Nelson reported that she did not think of that option and indicated that would have been the correct response to Resident A's behavior.

On 6/18/26, I interviewed DCSM Erika Gross. Ms. Gross reported she was working on 6/12/26 and that Resident A has been difficult to manage since he moved into the facility. Ms. Gross reported during the late afternoon she tried to redirect Resident A as he was trying to elope and he punched her in the ribs and told her to "shut the fuck up." Ms. Gross reported that he used profanity towards her and Ms. Nelson everyday. Ms. Gross reported that she was feeding Resident A dinner and he began spitting his food at her and was getting aggressive with the other residents. Ms. Gross reported she assisted Ms. Nelson with the gait belt as she thought it would be appropriate due to Resident A's aggressive behavior and trying to elope for the facility. Ms. Gross reported they released him after a short time, but he became violent again so they restrained Resident A again until his legal guardian arrived and she transported him to her home.

On 8/18/26, I reviewed Resident A's Assessment Plan for AFC Residents and noted that it did not indicate that he had any propensity to violence.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	It was alleged that Resident A was physically restrained without an order from a licensed health care professional. Based on

	interviews and review of documentation this violation will be established. Resident A was admitted to the facility on 6/3/26 and began having behavioral problems from the first day he moved into the facility. Ms. Nelson and the staff struggled to manage his behavior due to attempted elopement and physical aggression toward the staff and other residents. On 6/12/24, Resident A assaulted Ms. Nelson, Ms. Gross and was aggressive toward other residents, which resulted in Ms. Nelson choosing to restrain Resident A with a gait belt which was a clear violation of the administrative rule regarding the use of physical restraints.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/6/26, I shared the findings of the investigation with licensee, Stephanie Nelson by phone. Ms. Nelson acknowledged the findings and agreed to submit a corrective action plan.

III. RECOMMENDATION

Based on the submission of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW

6/29/29

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

6/29/26

Russell B. Misiak Date
Area Manager