STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235434	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronson Commons	23332 Red Arrow Highway Mattawan, MI 49071

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: #2790330, #2794131, #2798407Based on observation, interview and record review the facility failed to 1.) accurately assess and prevent an elopement of 1 (Resident #100) of 3 residents reviewed for elopement risk, resulting in an immediate jeopardy when Resident #100 left the premises on 2/14/26 at 5:04 AM, alone, unbeknownst to staff and was later located by staff at 5:55 AM approximately 100 yards from the facility; 2). Ensure safety during a mechanical lift transfer to 1(Resident #104) of 2 residents reviewed for safe transfers resulting in a fall with a head laceration.Findings include:The immediate jeopardy began on 2/13/26 and was identified on 3/11/26 when the facility failed to ensure the safety of and prevent an elopement for Resident #100 who was admitted to the facility on [DATE] and inaccurately assessed as not being an elopement risk. Resident #100 subsequently eloped from the building on 2/14/26 at 5:04 AM and was found by staff at 5:55 AM, the same day, approximately 100 yards from the facility near a neighboring house. Resident #100 was inappropriately dressed at the time of elopement with the recorded temperatures between 24 and 26 degrees Fahrenheit. On 3/11/26 at 10:47 AM, the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy. The surveyor confirmed by observation, interview, and record review the immediate jeopardy was removed on 3/11/26, but noncompliance remains at the scope of isolated and severity of actual harm due to not all staff receiving the education and sustained compliance has not been verified by the State Agency. According to [NAME] and [NAME], (2017) Patients with actual or potential risks to safety require a nursing care plan with interventions that prevent and minimize threats to their safety. Design your interventions to help a patient feel safe to move about and interact freely within the environment. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing – Ninth Edition - E-Book (Kindle Locations 25441-90239). Elsevier Health Sciences. Kindle Edition. Resident #100 Review of an Facesheet revealed Resident #100 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: history of falls, multiple rib fractures, and right frontal and vertex scalp hematoma with acute intercranial abnormality (a collection of blood beneath the scalp, often resulting from a head injury on the right side of the head). Review of an Elopement assessment for Resident #100 completed on 2/13/26 during admission, by Registered Nurse (RN) ZZ revealed Resident is NOT at Risk. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/10/26 at 11:30 AM, Registered Nurse (RN) L reported when a resident was identified as an elopement risk, a wander guard (a bracelet with an electronic transmitter that works with a mounted box at exit doors that alarms when a transmitter gets within range to alert staff of a person possibly leaving unattended from the building) was applied. RN L reported if the resident was assessed as not an elopement risk, no wander guard was applied. In an interview on 3/10/26 at 11:33 AM, Certified Nurse Assistant (CNA) YY reported when a resident was an elopement risk they wore a wander guard. CNA YY reported he looked for a wander guard on newly admitted residents. CNA YY reported when a resident was an elopement risk, that information was communicated in shift-to-shift report. CNA YY did not know of additional resources to use to determine if a resident was at risk for an elopement. In an interview on 3/10/26 at 11:35 AM, CNA F reported she would identify a resident at risk for elopement when she would look to see if a wander guard was present. CNA F denied being aware of additional resources to use to determine if a resident was at risk for an elopement. In an interview on 3/10/26 at 1:45 PM, RN L reported elopement assessments were to be completed on admission, day 3 and day 10 of stay. RN L reported an elopement assessment should be completed with a change in condition and after an elopement occurred. When queried if an elopement assessment could be completed at any time, RN L stated he was unsure, but thought there was a way to access the assessment to update the resident assessment. In an interview on 3/10/26 at 2:00 PM, RN R reported when a resident was assessed to be an elopement risk, they received a wander guard that was applied by a nursing manager, and they would need to be reevaluated during their stay. RN R reported when a resident was assessed to not be at risk for an elopement, no reevaluation was done. RN R reported she was unable to see resident assessments, and if a reassessment was needed the assessment would trigger when it was due. In an interview on 3/10/26 at 2:50 PM, RN ZZ reported she was the nurse who admitted Resident #100. RN ZZ reported when she received report from the transferring hospital about Resident #100, she was told Resident #100 was alert and oriented with some delirium related to recent narcotic use for pain management. RN ZZ reported when Resident #100 arrived at the facility she was terrified and had absolutely no clue what was going on. RN ZZ reported Resident #100 was not alert and oriented, voiced she thought someone was going to murder her, that she had been made a part of a sex trafficking ring, and her focus was to get out. RN ZZ reported Resident #100 verbalized (Name Omitted) transferring hospital was out to get her, had stolen her belongings including her coat, and were keeping her from her friends and family. RN ZZ reported Resident #100 also verbalized wanting to speak to her husband and son, and she repeatedly stated she wanted to leave. RN ZZ reported Resident #100 was frequently up walking around her room, to the bathroom, and to the sink and there was always a concern for elopement when a resident was wandering. RN ZZ reported Resident #100 had several broken ribs, was in significant pain, had an unsteady gait (walking pattern), walked hunched over, was retaining urine, and she was concerned Resident #100 was going to fall. RN ZZ reported she repeatedly had to inform Resident #100 that she was not going to hurt her, she was trying to help her. RN ZZ reported she informed Unit Coordinator (UC) V and LL that she needed additional help with Resident #100 and CNA MM was assigned to make additional rounds on Resident #100 throughout the shift. When queried about Resident #100's elopement assessment and risk status, RN ZZ stated She (Resident #100) was definitely an elopement risk; I would say, yes, that I documented her as an elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a subsequent interview on 3/11/26 at 2:57 PM, RN ZZ stated she did not assess and document Resident #100 as an elopement risk because I did not think she was physically capable of making it all the way to the door and I was hopeful and optimistic she would adjust to being in the facility. In an interview on 3/10/26 at 3:57 PM, UC V reported RN ZZ had told her she had concerns for Resident #100's status and behaviors after RN ZZ had received verbal report from the hospital and before Resident #100 had arrived at the facility. In an interview on 3/10/26 at 3:58 PM UC LL reported RN ZZ had requested help from her when Resident #100 was admitted to the facility. UN LL reported RN ZZ was in and out of Resident #100's room and had delegated tasks to her for another resident. UC LL reported she completed the delegated tasks and RN ZZ continued to complete the admission of Resident #100. In a telephone interview on 3/10/26 at 4:39 PM, CNA H reported she was assigned to Resident #100 during the third shift (11:00 PM to 07:00 AM) on the night she eloped and Resident #100 was wandering during the shift. CNA H reported the information she received in report about Resident #100 was that she was new to the facility, she had had a fall at home, had a knot on her head, and that she was fine. CNA H reported her first encounter with Resident #100 she noted she was very confused. CNA H reported Resident #100 wanted to call her son, was heard saying she didn't know how she got there (to the facility), asking for her husband and son, and that she wanted to leave. CNA H reported she had Resident #100 sitting in a chair at the nurse's station with her and was reassuring her she was safe prior to taking her lunchbreak at 3:00 AM. CNA H reported she returned to the unit after her break at 3:30 AM and Licensed Practical Nurse (LPN) I told her she had assisted Resident #100 to bed. CNA H reported she began her rounds and did not see Resident #100 again during her shift. In a telephone interview on 3/11/26 at 8:07 AM LPN I reported she was the nurse assigned to Resident #100 on the night she eloped from the building. LPN I reported she was told in report that Resident #100 had some confusion and she wasn't happy; didn't want to be here. LPN I reported at one point she had Resident #100 out at the nurse's station with CNA H. LPN I reported she had assisted Resident #100 into bed at about 3:30 AM and continued with her work on the unit. LPN I reported she had walked past Resident #100's room a couple of times after she helped her to bed and had observed her feet in the bed. LPN I reported she was outside of Resident #100's room at about 5:30 AM and was preparing to administer medications to Resident #100 when she discovered she was not in bed. LPN I reported she started looking for her in the building, to all the other courts (halls), other areas of the building, and notified other staff that she could not find her. LPN I reported she exited the building, searched the parking lot, and did eventually locate Resident #100 on the entryway steps to a neighboring house, sitting on the ground, wearing a hospital gown and grippy socks with a blanket wrapped around her shoulders. LPN I reported when she approached Resident #100, she asked her why was she out here and LPN I reported Resident #100 told her she was out here to get away from you guys and that she wants to go home. LPN I reported when Resident #100 said she wanted to go home she pointed to the house. LPN I reported she asked Resident #100 if she had fallen or if she was hurt and that Resident #100 replied I'm fine. LPN I reported she completed an assessment checking for injuries, called the staff in the building. LPN I reported she asked for extra blankets to be brought to her, because one blanket was not enough. When queried why one blanket was not enough, LPN I stated I was cold, so I knew she (Resident #100) was cold. LPN I reported she waited with Resident #100 for the paramedics to arrive and she was transferred to the local emergency department for evaluation. LPN I reported the cameras were reviewed and it was noted that Resident #100 exited the building on 2/14/26 at 5:04 AM and that she (LPN I) was to her just before 6 AM the same day. LPN I reported as far as she knew, Resident #100 was not a wander risk, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and she was not wearing a wander guard. In an interview on 3/11/26 at 9:45 AM CNA RR reported she was assigned to Resident #100 when she admitted to the facility. CNA RR reported when Resident #100 admitted to the facility she was very confused, made accusations that the transporting paramedics had stolen things from her, and that she wanted to get back to her husband, to the hospital. Review of Care Plan for Resident #100 revealed .Problem: I have a potential for sudden changes in my mental status related to my medical diagnosis- Interventions: please provide a supportive environment for me by maintaining safety.Problem: Mood: I have changes in mood due to medical diagnosis- Interventions: monitor for increased signs or symptoms of depression or anxiety. with initiation dates of 2/13/26. Review of Progress Notes for Resident #100 dated 2/13/26 at 2:00 PM revealed .Resident #100 is very confused asking to call her husband.Resident #100 is confused and cannot answer questions appropriately. She reports she is in severe pain. and no one will help her.Resident #100 states (Name Omitted) hospital is trying to [NAME] her and planning to keep her from her friends and family.Confusion reported to provider. Review of Progress Notes for Resident #100 dated 2/13/26 at 3:37 PM revealed .Resident #100 asked CNA staff if they would be willing to help her commit a mass murder to get the (Name Omitted) hospital people; after being found ambulating (walking) in room without walker. Review of Progress Notes for Resident #100 dated 2/13/26 at 4:37 PM revealed .Resident #100 is normally fully alert and oriented and can be anxious at times.Resident #100 having increased fear and confusion. Review of Progress Notes for Resident #100 dated 2/13/26 at 8:44 PM revealed .Resident #100 has calmed after talking with her son.son reports that Resident #100 is often anxious, but it (is) confused and unlike herself. Review of Progress Notes for Resident #100 dated 2/14/26 at 5:05 AM revealed .Patient.Seems anxious and overwhelmed at this moment. Review of admission History and Physical dated 2/13/26 revealed . Resident #100 was transferred to (Name Omitted) facility quite confused, agitated, and impulsive with abnormal behaviors on 2/13/26.Physical Exam.Resident #100 is ill-appearing.Neurological: Quite confused.Psychiatric: agitated, confused.Encephalopathy overnight during hospitalization that continues here with agitation, abnormal behaviors and impulsiveness.Patient quite confused, express that While I was in the hospital she was taken to basement filled with water and people bicycling and abnormal behaviors going on down there. Review of Significant Event for Resident #100 dated 2/14/26 at 6:45 AM revealed .Patient was discovered to be missing from room around 05:30 (5:30 AM). Previous to this time around 03:30 (3:30 AM) I assisted her back to bed after she had been up with us for a short period of time due to being slightly disoriented and confused about why she is here.At this time I searched around the building to each court, notified staff she was missing while looking, at the time that I had not found her within the building I exited the building and proceeded to look for her. I located her up the driveway at the neighbors house sitting on the walkway. She went up 6 stairs and about 20 feet up further from stairs (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	towards their house. When I found her I asked her if she was in pain, or if she fell. She stated she did not fall and had no pain. She stated she was trying to get home. At this time I stayed with her, ensured the blanket she had with her stayed around her shoulders. I contacted staff within (Name Omitted) facility to assist with getting more blankets, contacting emergency services to help safely get her up off the walkway and contact our (Name Omitted) Management/Administration. Assessing (Name Omitted) Resident #100 I did not see signs of fracture or harm. Waited for EMS (emergency medical services) before attempting to get her up off ground. Called building starting at 05:55 (5:55 AM), stayed on phone with LPN GG until EMS arrived at 06:10-06:20 (6:10 – 6:20 AM) During this time CNA brought extra blankets out for Resident #100 to help keep her a bit warmer until EMS could arrive. EMS assessed her also felt comfortable assisting her up to wheelchair. At his time per Nursing Home Administrator (NHA) A (Name Omitted) EMS service were instructed to take her (Resident #100) to (Name Omitted) hospital. [NAME] of Incident Review dated 2/16/26 revealed 2/14/26. 3:19 AM Per her report and recorded footage LPN I assists (Name Omitted) Resident #100 back to her room: LPN I reported she helped Resident #100 into bed .4:58 AM Recorded camera footage reveals that (Name Omitted) Resident #100 self-propelled out of her room towards the café, seated in her wheelchair with a hospital gown, non-skid socks, and blankets on her lap. She travels directly to the main entrance of the facility.5:03 AM (Name Omitted) Resident #100 is observed via recorded footage to push the handi-cap button on the wall to open the door. She self-propels through the door and stops in the vestibule. She is observed standing up from her wheelchair, arranging a blanket over her shoulders, rearranging an additional blanket on the seat of the wheelchair, then using the wheelchair as one would use a walker to push it through the front door. She can be seen on recorded footage walking along the west side of the parking lot, headed south through the lot.5:09 AM (Name Omitted) Resident #100 exits camera view on the south side of the driveway round-about.5:34 AM Per her report and recorded footage review, LPN I enters (Name Omitted) Resident #100's room to administer scheduled morning medications and notes (Name Omitted) Resident #100 is not in her room. LPN I reports she immediately began a room-to-room search and notified other staff to assist.5:45 AM while other staff continued to search inside the facility, LPN I exited the facility to search the exterior. She located (Name Omitted) Resident #100 approximately ten minutes later, approximately 100 yards away from the facility, near the neighboring homes front porch, sitting on the ground. LPN I remained with (Name Omitted) Resident #100 while she phoned emergency services for assistance. She also called the facility to advise that (Name Omitted) Resident #100 had been located. She asked staff to bring more blankets as they waited for EMS to arrive.6:03 AM LPN GG phoned. NHA A to advise of incident. While waiting for EMS, LPN I reports she asked of (Name Omitted) Resident #100 if she fell and she said no. LPN I asked (Name Omitted) Resident #100 if she was injured or had any pain and she said no. LPN I performed a brief physical assessment noting no obvious signs of injury. LPN I reports she asked (Name Omitted) Resident #100 what happened and she said she was trying to get home.6:10 AM approximately EMS arrived. EMS noted no signs of injury. NHA A requested that (Name Omitted) Resident #100 be taken to the emergency department for evaluation.6:20 AM EMS departs with (Name Omitted) Resident #100 enroute to (Name Omitted) hospital.Patient review.throughout her hospital stay (Name Omitted) Resident #100 began to experience confusion short-term memory loss and poor insight. upon arrival to (Name Omitted) facility (Name Omitted) Resident #100 exhibited non-sensical conversation, agitation.Following this event (Name Omitted) Resident #100 was evaluated in the emergency department and found to have E. Coli in her urine and encephalopathy with paranoia. Review of Discharge Summary for Resident #100 dated 2/19/26 revealed .admission date 2/14/26.Primary Diagnosis: encephalopathy with paranoia- suspected drug induced, possibly related to tramadol and oxycodone- resolved.HPI at time of presentation.Presented to the ED (emergency (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	department) brought in by ambulance from (Name Omitted) facility for evaluation of AMS (altered mental status). Upon arrival to (Name Omitted) facility patient confused and agitated with reported paranoia and hallucinations.This morning patient eloped from (Name Omitted) facility and was found 100 m (meters) away at surrounding house. In an observation and interview on 3/12/26 at 7:25 AM, upon entrance to the facility, a staff member CNA E was observed sitting at a desk placed next to the entrance door. CNA E reported she was assigned to sit at the desk and observe the door for the duration of her shift that started at 11:00 PM and ended at 7:30 AM. CNA E reported that the front doors to the building did not lock from the inside; anyone could push on the door, open them and exit the building. CNA E reported the outer doors to the vestibule were open, but the doors to the building from the vestibule were locked after hours and someone had to let a visitor into the building. The immediate jeopardy began on 2/13/26 and was removed on 3/11/26 when the facility took the following actions to remove the immediacy: On 2/17/26 Elopement and missing person policies and procedures were reviewed. On 3/11/26 the elopement assessment tool scoring was modified to enhance identification of safety risks. On 3/11/26 all 90 residents in the building were reassessed for elopement risk. Two residents were identified as elopement risks related to the changes in the elopement assessment tool and wander guards were initiated for both residents. On 3/11/26 all wander guards and alarms were checked for functionality. On 3/11/26 comprehensive education on elopement prevention including ongoing assessments, definitions, exit seeking behaviors, and role expectations to all licensed nursing staff and certified nursing assistants began with 88 of 172 total employees being educated. Staff development instructor, leaders, or designee will provide education to the remaining employees prior to the start of their next working shift. Education material and completion to be reviewed quarterly at the QAPI meeting. Effective immediately, 3/11/26 nursing leaders will perform weekly audits of new admissions for the next 4 weeks to ensure elopement assessments are done on admission, and up to date and that there is a care plan to address the risk if any. On 3/11/26 a workstation was created at the main entrance to the building and scheduled staff to monitor the flow of traffic in and out of the building (Monday- Friday 1700-0730 (5:00 pm to 7:30 AM) and weekends/holidays staffed 24/7. On 3/11/26 a Red Box Audible Alarm was installed at the main entrance. Alarm will be active 2300-0600 (11:00 PM to 6:00 AM) and maintained by entrance attendant. Alarm is activated any time the door is opened. Resident #104 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Facesheet revealed Resident #104 was a female. Review of a Diagnosis List revealed Resident #104 had pertinent diagnoses which included: moderate cognitive impairment and generalized weakness. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 1/15/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #104 was moderately cognitively impaired. Further review of said MDS revealed Resident #104 was dependent on staff to roll left and right (the ability to roll from lying on back to left and right side.), sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed with no back support), sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair [or wheelchair]), toilet transfer (the ability to get on and off a toilet or commode) and tub/shower transfer (the ability to get in and out of a tub/shower). Review of an Incident/Accident Report report for Resident #104 revealed, Incident On 2/20/26, (Resident #104) was transferred to (hospital name omitted) following an incident during which she fell from the Hoyer (a specialized type of equipment with a sling used to safely transfer patients between surfaces) sling (a specialized harness used with a hoyer lift for safe patient transfers).Incident Review Staff was assisting (Resident #104) to transfer from her bed using a Hoyer lift. As the lift was pulled away from the bed, (Resident #104) was unable to maintain arm support necessary for the sling that was used. She immediately slid out of the sling and landed on the legs of the machine.The nurse completed an assessment and pressure was applied to her head wound.(Resident #104) was transported to the hospital via stretcher at 0830 (8:30 AM).Head laceration was repaired with four staples. Review of Resident #104's Emergency Department Notes dated 2/20/26 revealed, Patient was brought in by ems (emergency medical services) from (facility name omitted) due to a fall out of the hoyer. Patient landed on her head at bed height.Patient has a history of dementia and Alzheimers (a type of dementia). Shoulder pain and back pain. LAC (laceration) to the back of head.Procedure.The laceration was closed with staples.Other Items: Staple count: 4.The patient tolerated the procedure well. In an interview on 3/10/26 at 12:59 PM, Certified Nurse Aide (CNA) O reported that she and CNA YY got the sling on Resident #104 and CNA YY was lifting Resident #104 up and she went around the other side to guide Resident #104 and before she could get to Resident #104, she fell. CNA O reported they had used the sling they use to put her on the toilet (referred to as a hygiene sling – a specialized sling designed with a large opening under the buttocks and lower back typically used for toileting) because that was the sling in the room at the time of the transfer and they had been using that sling on Resident #104 for months. CNA O reported after the fall, management removed the sling from Resident #104's room. In an interview on 3/10/26 at 1:08 PM, CNA YY reported he and CNA O were transferring Resident #104 from her bed to her recliner chair by placing the sling underneath her, properly placing the back part where it was supposed to be, crossing the leg portion, and looping the bands through each other. CNA YY reported they raised the hoyer and lowered the bed at the same time. CNA YY reported by the time he pulled the hoyer away from the bed, he looked up and Resident #104 had fallen backwards landing on her upper left shoulder and hitting her head. CNA YY reported they had used the sling they always used with Resident #104 which was the hygiene sling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a follow-up interview on 3/11/26 at 8:50 AM, CNA YY reported the CNAs will use the slings that are in the resident rooms. CNA YY reported they used the hygiene sling for Resident #104 because that was the one in her room at the time of the transfer on 2/20/26. CNA YY reported the care plan does not indicate what type of sling to use. In an interview on 3/10/26 at 1:21 PM, Supervisor of Rehabilitation (SR) QQ reported CNA O and CNA YY had been using the hygiene sling to transfer Resident #104 at the time of her fall on 2/20/26. SR QQ reported staff should have used the standard hoyer sling (a type of sling that provides full body support). In a follow-up interview on 3/10/26 at 2:26 PM, SR QQ reported prior to Resident #104's fall on 2/20/26, therapy had not assessed Resident #104 for the appropriateness of using the hygiene sling for transfers. In an interview on 3/10/26 at 1:44 PM, Registered Nurse Unit Coordinator (RNUC) V reported at the time of Resident #104's fall on 2/20/26, Resident #104 was in the hygiene sling. RNUC V reported that sling was her preference. RNUC reported Resident #104 was normally able to use her upper body to support herself and she just couldn't that day and she dropped. RNUC V reported on re-evaluation it was determined that the hygiene sling was not an appropriate sling to use for Resident #104 but at the time it was the appropriate sling until it wasn't. In a follow-up interview on 3/10/26 at 2:51 PM, RNUC V was requested to provide this surveyor with evidence that the hygiene sling was Resident #104's preference. RNUC V reported there was no such documentation. In an interview on 3/10/26 at 3:02 PM, Nursing Home Administrator (NHA) A was requested to provide this surveyor with Resident #104's assessment indicating that she was appropriate to use the hygiene sling for transfers. In an interview on 3/10/26 at 3:32 PM, NHA A reported the facility did not have an assessment for Resident #104 indicating that she was appropriate to use the hygiene sling for transfers. In an interview on 3/10/26 at 3:42 PM, Physical Therapist (PT) BB reported in order to use the hygiene sling, a resident would need to keep their shoulders engaged and have enough core strength to counterbalance. PT BB reported the hygiene sling was a very specific type of sling and it would not be appropriate for everybody. PT BB reported she would not prescribe a resident to use a hygiene sling unless they were assessed to be appropriate to do so. In an interview on 3/11/26 at 10:50 AM, Occupational Therapist (OT) TT reported a hygiene sling was supposed to be used for toileting purposes. OT TT reported it would not be an appropriate sling to be used if a resident was being transferred from a bed to a chair. OT TT reported it would be a good idea for a resident to be assessed before using a hygiene sling because it is a very specialized type of sling. OT TT reported without assessing Resident #104, she would not know if Resident #104 was appropriate for the hygiene sling. OT TT reported when therapy recommended a hoyer lift to be used, normally it would be a standard hoyer sling that was used for the transfer, not a hygiene sling. OT TT reviewed Resident #104's therapy notes and reported therapy had not assessed Resident #104 for use of the hygiene sling. OT TT reported OT and PT expected Resident #104 to be using the standard hoyer sling for transfers. OT TT reported if it was a resident preference to use the hygiene sling, it would be documented that they were educated that it was not safe to use the hygiene sling for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235434	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronson Commons	23332 Red Arrow Highway Mattawan, MI 49071

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	transfers and that therapy did not recommend that. OT TT reported for a normal transfer, a hygiene sling should absolutely not be used because it is less safe than a standard hoyer sling and does not provide enough support. OT TT reported when therapy reco

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure a Registered Nurse (RN) served full time in the role of Director of Nursing potentially affecting all 89 residents that reside in the facility.Findings include:On 3/10/26 at 9:50 AM, surveyors entered the facility and were met by Staff Development/Registered Nurse (SD/RN) III. Surveyors requested to meet with either the Nursing Home Administrator and/or the Director of Nursing and SD/RN III reported the NHA and DON were the same person.On 3/10/26 at 9:55 AM, Director of Nursing (DON) B while meeting with survey team in the conference room, reported she was also the Executive Director/Nursing Home Administrator (NHA) A at this time.In an interview on 3/11/26 at 7:42 AM, DON B reported she had held the position of DON for about 5 years, and in August of 2025, the previous NHA vacated the position and she assumed the role. DON B reported she has been the only person in both roles since the previous NHA left until present. DON B reported here role as DON included auditing and education, new processes, policy updates, employee issues, a bit of payroll and budget, staff meetings, skills fairs, infection prevention meetings, clinical oversight, and IDT (interdisciplinary) meetings. DON B reported she was responsible for managing skills fairs, running IDT meetings and the daily check meetings. DON B reported her role as DON has several parts, many of which she was delegating to the unit coordinators. DON B reported in addition to her DON duties, as the interim NHA she was now responsible for rehabilitation department, activities department, dietary, social work, and that the social work supervisor was on a medical leave.In an interview on 3/11/26 at 10:41 AM, Unit Coordinator (UC) X reported she had been given multiple delegations by DON B.In an interview on 3/11/26 at 10:42 AM, DON B reported she was one person doing 40 hours' worth of work in two roles and was not always performing quality work. DON B reported things could have been managed better with better oversite if there were two people to fulfill the roles of NHA and DON. DON B stated there are meetings I can't attend, and things I cannot do because of the things related to the executive director position. My responsibilities as the DON were delegated to and shifted to the unit coordinators and their responsibilities were shifted accordingly.In an interview on 3/11/26 at 10:46 AM UC LL reported access to DON B had been limited when trying to work through something. UC LL reported DON B was just not as available as she used to be when she wasn't doing dual roles.In an interview on 3/11/26 at 10:52 AM DON B reported she had not been able to welcome staff to discuss things, she had to direct them to their direct leaders. DON B reported she could not be as hands on as she had been before with the clinical staff. DON B reported she felt as though she had been less available for the staff.In an interview on 3/11/26 at 10:58 AM, UC M reported one week after she started, she was placed into the safety committee spot that DON B had previously occupied, due to the DON B's additional role as NHA. UC M reported she had been learning on the fly since she started. In an interview on 3/11/26 at 11:01 AM, DON B stated UC M took my place on the safety committee, I had been on that committee for years, but I could no longer fulfill that role. I was already doing two jobs; I couldn't do three! DON B reported UC LL does more interviews now. DON B also stated I used to do the nurse aide training program, and I am no longer involved due to the responsibilities of the NHA role, Staff Development (SD) III now leads the nurse aide training program. DON B reported in the role of interim NHA she was now responsible for the whole building.In an interview on 3/11/26 at 11:07 AM, UC X reported DON B was no longer as available to touch base or discuss things throughout the day as she had once been.Review of Facility Assessment dated August 8, 2025, revealed .Interim Executive Director and Director of Nursing were the same name, the same person.Review of Employee Report revealed no noted named employee listed as Executive Director.