STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess elopement risk assessment, ensure exit doors were properly secured, and provide adequate supervision to prevent an elopement from the facility for one Resident (#1) of 1 resident reviewed for elopement risk. This deficient practice resulted in an Immediate Jeopardy when Resident #1 exited the facility unsupervised for approximately 30 minutes in 53 degree weather without proper attire and was found in a ditch where Resident #1 fell and was complaining of being cold and had head and neck pain, which required transfer to the Emergency Department (ED) for evaluation. after 30 minutes being outside in 53 degree weather without proper attire or footwear.This deficiency pertains to Intake 2635984.Findings include:Resident #1 (R1)The Immediate Jeopardy (IJ) began on 10/6/25 at 5:13 a.m., when R1 eloped from the facility which was undetected by facility staff. R1 was subsequently observed by incoming facility staff arriving for day shift. R1 was found laying in a small ditch adjacent to the main entrance street on 10/6/25 at approximately 5:45 a.m. The Nursing Home Administrator (NHA) was notified of the IJ on 10/7/25 at 3:45 p.m. At that time, a written plan for removal of the immediacy was requested from the facility. This Surveyor confirmed by observation, interview, and record review that the immediacy was removed on 10/8/25 at 9:23 a.m., however, noncompliance remains at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA). Review of a Facility Reported Incident (FRI), submitted to the State Agency (SA) on 10/6/25, revealed the following facility reported event: .Incident Summary: DON (Director of Nursing was contacted by SSD (Social Services Designee) at 5:56 a.m., that upon arrival to work she (SSD) observed [R1] sitting outside in the ditch in front of the gazebo . When did the problem occur? 10/06/2025 05:13 a.m. Review of R1's Minimum Data Set (MDS) assessment, dated 8/19/25, revealed readmission to the facility on 2/28/25, with active diagnoses that included the following, in part: progressive neurological disease, diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, and macular cyst of right eye. R1 scored 7 of 15 on the Brief Interview for Mental Status (BIMS) reflective of severe cognitive impairment. Review of R1's Unwitnessed Fall Incident Report, dated 10/6/25 at 05:45 (5:45 a.m.), revealed the following, in part: Resident found outside of building sitting in grass by curb on her buttock. Wheelchair was off to the side. No visible injuries. Resident has been searching for her car all night and has asked if anyone knows where [Town Name] is. Resident states hitting her head and that this is not her home and that she does not want to be here and was looking for her car . Description: Vital signs initiated no complaints of pain with passive range of motion. There are no visible signs of injury at present time when checking resident's skin. Resident taken to hospital? N (NO). Injury Type: No Injuries observed at time of incident. Level of Pain: 0 (zero) . Mobility: Ambulatory without assistance. Mental Status: Oriented to Person, Oriented to Place . NOTES: Resident is confused and has been searching for her car all night. States that she wants to go home and does not want to be here. Resident is ambulatory and is unstable on her feet . Other info: Exit seeking. Not wanting to be here in facility. Incident report completed by LPN C.Review of the facility's surveillance video on 10/6/25 at approximately 8:45 a.m., beginning on 10/6/25 at 3:51 a.m., in the presence of the Nursing Home Administrator (NHA) and DON revealed the following wandering and elopement observations, in part:3:51 a.m. - R1 enters her room pushing wheelchair.3:54:34 a.m. - R1 exits her room pushing wheelchair down the 100 Hall to the nurses' station.4:01:00 a.m. - R1 sitting in wheelchair at nurses' station. Licensed Practical Nurse (LPN) C leaves R1 unsupervised and walks to and enters the bathroom with a cellphone in her hand.4:10:22 a.m. - R1 self-propels wheelchair down the activity/dining room Hall unsupervised.4:11:16 a.m. - R1 enters the dining room, unsupervised.4:13:29 a.m. - R1 Stands up from wheelchair, 4:13:36 R1 sits down in wheelchair, 4:13:56 R1 stands up from wheelchair. Unsupervised.4:14:16 a.m. - R1 pushes wheelchair around the dining room, unsupervised.4:14:42 a.m. - LPN C exits bathroom with cellphone in hand. (14 minutes, 42 seconds in bathroom)4:14:56 a.m. - LPN C observed with R1 in the dining room. 4:15:30 a.m. - LPN C observed using personal cell phone at the nurses' station.4:20:20 a.m. - R1 pushes wheelchair back toward front exit door; unsupervised.4:26:24 a.m. - R1 walks back toward nurses' station pushing wheelchair; unsupervised.4:24:35 a.m. - R1 pushed wheelchair toward nurses' station - unsupervised.4:24:46 a.m. - (Certified Nurse Aide) CNA D walks into the break room.4:28:23 a.m. - R1 walks down 100 Hall and back up 100 Hall and looks in her room at 4:33:35.4:31:38 a.m. - CNA B goes downstairs on the elevator. Returns at 4:49:36 a.m.4:34:02 a.m. - R1 no longer on the 100 Hall. R1 moves to nurses'