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	05/11/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure supervision, including following care plan interventions to prevent a fall for 1 Resident (#1) of 3 residents reviewed for falls with injury. This deficient practice resulted in a fall with major injury (pelvis fracture) for R1.Findings include:This deficient practice pertains to Intake #2994738.Resident #1 (R1)Review of R1's Comprehensive Minimum Data Set (MDS) assessment, accepted 3/24/26, revealed an admission to the facility on 9/30/24, with active diagnoses that included the following, in part: hip fracture and seizure disorder. R1 scored 3 of 15 on the Brief Interview for Mental Status (BIMS), reflective of severe cognitive impairment.Review of R1's admission Record, printed 4/17/26, revealed the following diagnoses, in part; epilepsy, lack of expected normal physiological development in childhood, anoxic brain damage, fracture of left femur (onset date of 9/30/24), unsteadiness on feet, other abnormalities of gait and mobility, left femur neck fracture (onset date of 3/9/26), repeated falls and dependence on wheelchair (for mobility).On 5/11/26 8:20 p.m., observation of a surveillance video, retained from 4/14/26, of R1's fall with major injury (pelvis fracture) revealed the following, in part:8:32:09 p.m. through 8:36:26 p.m., no staff were observed at the nurses' station in the facility.8:32:09 p.m. - Licensed Practical Nurse (LPN) A enters the medication room, joining LPN B who was already in the med room and shuts the door.8:32:22 p.m. - LPN A takes their personal cell phone out of the right scrub top pocket and continues use of the personal cell phone until 8:34:33. No nursing duties observed.8:34:33 p.m. - LPN A observed to take a drink, converse with LPN B, stand inactive, without the performance of any nursing duties until 8:36:25 a.m.8:35 38 p.m., LPN B observed on their personal cell phone.8:36:24 p.m., R1 is observed falling to the floor outside of the closed medication room door.8:36:26 p.m., LPN A, followed by LPN B leave the medication room to assist R1 who is observed on the floor.Review of R1's Post-Fall Assessment Form, dated 4/14/26 at 1935 (7:35 p.m.), revealed the following, in part: 1. Was this fall observed ? YES. If yes, by whom: [LPN A] and [LPN B].2. Was the resident identified as high risk prior to the fall. YES .4 Why do you (R1) think you (R1) fell? Lost balance - standing at Med Room window.The post-fall assessment form was completed by LPN B, although the surveillance video appeared to show LPN A looking out of the med room window as R1 was standing on the other side looking into the room; immediately prior to R1s' fall.Additional information on the Post-Fall Assessment form, completed by the IDT (Interdisciplinary Team) and signed on 4/15/26, included: Care plan was not being followed as medication room door was closed with 2 nurses in med room. Corrective action will be completed with nurses involved in incident.During an observation on 5/11/26 at 10:00 a.m., R1 was observed in the therapy room, sitting in his wheelchair with socks on his feet. During an interview at this same time, RN C reported R1 routinely refused to wear socks or shoes in the facility.Review of R1's Fall Care Plan prior to the fall on 4/14/26 at 8:36 p.m., revealed the following, in part: Nurses were left this message so that if I (R1) am looking for them in the med room, I can access them. If you are in the med room the door needs to be left open. Have the door shut when you are giving report and counting. Date Initiated: 01/26/2026.Review of the facility Incident Summary submitted to the State Agency on 4/16/2026 at 5:54 p.m., revealed the following, in part: . Resident (R1) did have a care plan intervention at time of (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 - Minimal harm or potential for actual harm Residents Affected - Few	fall stating ?Nurses were left this message so that if I am looking for them in the med room, I can access them. If you are in the med room the door needs to be left open. Have the door shut when you are giving report and counting.' Upon review of the cameras, this care plan intervention was NOT being followed by nurses who were in the med room at the time of fall.the two LPNs (LPN A and LPN B) were given a formal written counseling on following care plans because it was in place at the time of fall . Resident is still at baseline prior to fall, propelling independently throughout the facility.Review of R1's ED (emergency room) Provider Note, dated 4/16/26, revealed the following, in part: CT scan demonstrates superior and inferior pubic rami (pelvis) fractures. I did reach out to . [Physician Name] who reviewed the scans. He felt like this was nonoperative and the patient can weight-bear as tolerated .Final Diagnosis: Left superior pubic rami fracture, left inferior pubic rami fracture .Review of LPN A's and LPN B's Employee Counseling Forms, dated 4/15/26 and 4/16/26, respectively, revealed the following, in part: Resident [R1] fell while standing to look into medication room. Cameras were reviewed and at the time of this fall medication door was closed and LPN was inside med room with another nurse. Nurse education from 1/26/26. If you are in med room the door needs to be left open. Have door shut when you are giving report and counting . Safety Violation.Review of the Charge Nurse (RN or LPN) Job Description, received from the facility on 5/11/26 at 10:15 a.m., revealed the following Additional Tasks: .Follows appropriate safety and hygiene measures at all times to protect residents and themselves . Agreement to abide by all standards, policies, and procedures of the facility, including the facility's compliance and ethics program, is a condition of employment.Review of the Personal Cell Phones policy, revised 7/18/25, revealed the following, in part: Policy: It is the policy of this facility to provide quality care to our residents without interruption. Policy Explanation and Compliance Guidelines: 1. The facility prohibits employees from using personal cell phones for any reason on the nursing units or in working areas of the facility. 2. This includes calls, texts, social media or any other use of cell phones. 4. Cell phones may be used by employees while on a scheduled break in break areas only. 5. Employees who violate this policy will be subject to disciplinary action up to and including termination of employment.A telephone interview was attempted on 5/11/26 at 1:48 p.m. with LPN A who appeared to witness R1's fall on 4/14/25 in the surveillance video observation. A voicemail message was reach which included LPN A saying that they may you back or they may not. Message left to return call to this Surveyor. A return call was not received form LPN A prior to the close of the abbreviated survey on 5/11/26.During interviews on 5/11/26 at 9:54 a.m., 9:55 a.m., and 9:56 a.m., when asked about communication or written education regarding leaving the medication room door open on nights when staff are reduced within the facility, Registered Nurse (RN) C, RN D, and LPN E, respectively, all confirmed they were aware of that information.Review of R1's Fall Care Plan post 4/14/26 fall, revealed the following additions, in part: I have a pressure sensor alarm on my wheelchair that will alert staff when I stand up. Date Initiated: 04/16/2026.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:1. Identification of the noncompliance with care plan interventions at the time of R1's fall on 4/15/26.2. Education of all nursing staff, on 4/16/26, regarding the importance of resident care plan review, compliance with resident care plans, and the importance of keeping the medication room door open on night shift for resident safety, and3. Monitoring of compliance with the medication room door remaining open, during night shift between 4/16/26 - 4/30/26, when nursing staff were in the medication room.The facility was able to demonstrate monitoring of the corrective action and sustained compliance as of 4/30/26.