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	06/30/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely provide requested medical evaluation and treatment for two Residents (R1 & R4) out of four residents reviewed for a change in condition. This deficient practice resulted in delayed medical treatment, worsening of condition, and dissatisfaction with care. Findings include:The deficiency pertains to Complaint #3035494.All times noted are Eastern Daylight Savings Time (EDST).Resident R4 Review of Complaint Intake #3035494 revealed allegations that included the following, in part: 1. The facility staff failed to provide care for and services for a significant change in condition, and 2. The facility failed to allow the resident's representative to participate in care decisions.Review of R4's Minimum Data Set (MDS) assessment, dated 5/22/26, revealed R4 was admitted to the facility on [DATE] with active diagnoses that included the following, in part: Alzheimer's disease, and medically complex conditions. R4 was documented with severely impaired cognition, never/rarely made decisions.A telephone interview was conducted on 6/29/26 at 5:00 p.m. with Family Member (FM) A. FM A said they didn't know why the nurse didn't recognize she needed to go to the hospital on Sunday, 5/17/26. [Activated Durable Power of Attorney (DPOA)] B voiced his concerns to more than one person about (R4's) pain during the week (Thursday) prior to R4's transfer to the hospital on Sunday 5/17/26. On Sunday 5/17/26, DPOA B said something was wrong. DPOA B got them to call the facility van transporter, but the van lift was not operational. The facility called an ambulance, when DPOA B said [R4} needed to get to the hospital. R4 was transferred to the [Hospital Name] emergency room (ER) and was admitted to the hospital for 2 nights. FM A stated, In February [R4] was placed at [Facility Name] as a resident for following a UTI (urinary tract infection) and Sepsis. We had the reassurance that if R4 had anything unusual in her behavior or personality that is the first thing they check (for a UTI). [R4] had a decline in health about a week before she was hospitalized . She had a severe UTI .and a stool impaction.Review of the [Hospital Name] History of Present Illness, dated 5/17/26, revealed the following, in part: Patient is an [AGE] year-old with a history of dementia, breast cancer, CAD (coronary artery disease), hypothyroidism, and hypertension who presents from nursing home via EMS (emergency medical services)due to concerns for confusion and altered mental status. Apparently, this is gotten worse since Thursday . Husband saw her a few days ago and said that she is not acting appropriately . Medical Decision-Making: Upon arrival to the emergency department the patient (R4) is tachycardic (elevated pulse), febrile (elevated temperature). She is mildly confused according to husband. I am most concerned for sepsis (Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.). Given that she cannot give us a lot of information we will obtain CT head, chest, abdomen, and pelvis as well as urinalysis respiratory panel. Patient's blood work did come back with elevated white count, elevated creatinine concerning for an acute kidney injury, as well as a slight elevation of troponin. Initial concern for the troponin would be demand ischemia given that the patient is likely septic . CT was also notable for proctitis (inflammation of the rectum) and a stool ball. I suspect this is the cause of her sepsis. She could also have a urinary tract infection. Regardless she was given vancomycin and Zosyn empirically . I did (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform a fecal dis-impaction . Was able to get a large amount of stool out. Will give her an enema following this. Given that she meets the SIRS (system inflammatory response system) criteria for sepsis we will plan for admission for further treatment and monitoring. Final Diagnosis: Proctitis, cystitis (inflammation of the bladder), sepsis, NSTEMI (a type of heart attack), acute kidney injury. Disposition: Admit to floor, Condition on Disposition: Serious. Urine culture was positive for gram-negative rods/Pseudomonas aeroguinosa.Resident R1Review of R1's admission Record, 6/30/26 at 9:54 a.m., revealed R1 was admitted to the facility on [DATE] with diagnoses that included the following, in part: diabetes mellitus, personal history of urinary tract infections (UTIs), and congestive heart failure. While a Resident of the facility R1 was diagnosed with Alzheimer's disease with late onset effective 2/19/25 and unspecified dementia on 8/22/25. R1 had an activated DPOA; DPOA C. Review of the facility admission and Discharge list for the previous three months (April, May, and June), revealed R1 was discharged to the ER on [DATE].During an interview on 6/30/26 at 9:18 a.m., when asked about transfers to the ER for R1, the Nursing Home Administrator (NHA) stated, [R1's DPOA] wants us to always send her out to the hospital.Review of R1's Progress Notes revealed the following, in part:5/28/26 17:17 (5:17 p.m.) - Residents DPOA called and expressed that resident is being irrational, and behavior is not normal. Expressed resident is fixated on daughter and her sisters bringing her home .SN (skilled nurse) called writer and discussed concern with resident yelling at staff while staff are helping. Staff laid resident down per her request and then ten minutes later put her light on stating she'd been left all day. Discussed this with DPOA, DPOA expressed she's been the same with her and other family members. Write is sending secure message to [Physician D] with concerns of ongoing confusion and agitation. SN/staff are monitoring resident and will call MD (physician) if situation gets worse. Resident has received cares and needs have been met.5/31/26 05:49 a.m. (5:49 a.m.,) - Very confused this morning. Wanted staff to take her home. She keeps taking her cannula off and it's been renewed several times during the shift .5/31/26 16:27 (4:27 p.m.) - The Change in condition/s reported on this CIC Evaluation are/were: Altered metal status, Shortness of breath, tired, weak, confused, or Drowsy. Outcomes of Physical Assessment, in part: Respiratory Status Evaluation: Shortness of breath, Labored or rapid breathing, Cough, Abnormal lung sounds/rales, rhonchi, wheezing).Primary Care Provider responded with the following feedback: A. Recommendations: First was to give nebulizer treatment then she said to send her for evaluation . C. New Intervention Orders: Oxygen (if available).5/31/26 17:25 p.m. (5:25 p.m.) - She hasn't been feeling 100% today. She sounds very congested, her lungs sound wet .She is more lethargic and appears to be SOB (short of breath). She says she is not having a hard time but visibly she looks miserable . her breaths are shallow. She also looks pale to me. [Physician D] ordered nebulizer first then this writer was informed by the administrator that [Physician D said to send her to the ED (emergency department) for evaluation.6/1/26 04:20 (4:20 a.m.) - Res (R1) admitted to [Hospital Name] for pneumonia.Review of R1's 5/31/26 ED Provider Note - History of Present Illness included the following, in part: [AGE] year-old woman with past medical history significant for type 2 diabetes, essential hypertension, hyperlipidemia, CHF, who presents from the nursing home with a chief complaint of altered mental status and shortness of breath. [Named] nursing home found the patient to be hypoxic while on 1.5 L. They noted the patient's respiratory effort to be increased and that the patient was more confused than normal. EMS placed the patient on 3 L of oxygen which improved her oxygenation, though the patient's mental status did not improve. EMS found the patient's blood sugar to be 178, GCS 14, heart rate 95, saturation of 91%, blood pressure 138/73, temperature 98.1. EMS gave the patient a DuoNeb breathing treatment. Medical Decision Making: ED Course: Initial vitals were remarkable for heart rate of 95. Physical exam showed an ill-appearing elderly woman lying in the ER bed with moderately increased work of breathing, coarse breath sounds bilaterally, and mild generalized abdominal tenderness without any area of worst tenderness. Differential diagnosis is broad and includes respiratory viral illness, PE, pneumonia, MI, UTI, intra-abdominal infection, among numerous other diagnoses. Infectious workup was initiated. DuoNeb breathing treatment, 125 mg (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Solu-Medrol was ordered for the patient. Labs came back remarkable for a severe anemia of 7.4 . respiratory viral panel showing human metapneumovirus. CT of the chest, abdomen, pelvis showed dense bilateral pulmonary infiltrates most prominent in the right upper lobe. Patient was admitted to [Hospital Name] for further treatment of bilateral pneumonia, acute hypoxic respiratory failure, likely demand ischemia, chronic diastolic CHF, fluid overload, severe anemia, human metapneumovirus infection.During a telephone interview on 6/30/26 at 9:57 a.m., DPOA C was asked if there were any concerns related to timely addressing changes in condition for R1 as well as the facility responding to the DPOA's concerns related to requests for medical care and/or treatment. DPOA D stated, (One) of the last times she was there (at the ER) I was telling them (the doctor) that something was not right with her . I was telling them right before I left that [R1] was getting mean and started hallucinating. I knew she was getting some kind of infection. The doctor (Physician D) and said her lungs were fine . I had been requesting that she go to the hospital, and they said that I could not do that . [R1's] behavioral therapist called [Facility Name] and me saying there was something wrong with [R1]. They (facility) sent her out (to the ER) on the 31st. They brought her back on the 6/3/26 . I was very unhappy that they did not send her to the hospital when I wanted her to go.During an interview on 6/30/26 at 12:30 p.m., the NHA said that the facility protocol has been to contact [Physician D] prior to discharging any resident to the ER. The NHA confirmed that she had received complaints from facility resident families about not being listened to regarding treatment of their loved ones in the facility and not sending them out (to the ER) for care concerns. The NHA said none of the family members had written grievances related to their verbal complaints but acknowledged administration staff had met with some of the families expressing concerns.During an exit conference on 6/30/26 at 4:16 p.m., the NHA and Interim Director of Nursing (DON) nodded their heads up and down, in agreement, that families had expressed concerns with the delay in transfer to the ED. The NHA said the protocol of always waiting for the physician to order the transfer would be re-examined to expedite emergency medical care for facility residents.